|  |  |  |
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| **Logo** | **Marie Curie Talk about it**  **Client Referral** | **Client Reference:**  ……………………..  **Date ………………** |

This form will be completed for each client referral taken for the service. Once all of the information captured is inputted onto the database, this form ***must*** be shredded.

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| **1. Service criteria – does the client being referred meet the service criteria?** | | | |
| *(please tick accordingly)* | | **YES** | **NO** |
| **Are they aged over 18?** |  |  |  |
| **Do they have a life limiting condition?** |  |  |  |
| **The person is well and would like to know more about ACP** |  |  |  |
| **Primary Diagnosis.** |  |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2. Referrer’s details** | | | | | | | | | |
| *(Complete details of contact who made the referral)* | | | | | | | **YES** | **NO** | |
| **Professional referral** | | | | |  | |  |  | |
| **Self-referral** *(including referrals from a carer/family/friend)* | | | | |  | |  |  | |
| **Title** | Mr  Mrs  Miss  Ms  Dr  Other …………………….. | | | | | | | | |
| **Name** |  | | | | | | | | |
| **Address**  **Private home**  **Care home**  **Hospital**  **GP**  **Family member** |  | | | | | | | | |
| **Post code** |  | | | | | | | | |
| **Tel no** |  | | | | | | | | |
| **Email** |  | | | | | | | | |
| **Organisation** *(professional referrals only)* |  | | | | | | | | |
| **Job title** *(professional referrals only)* | **………………………………** | | | | | | | | |
| **Relationship to client** *(self-referrals only)* | Spouse  Sibling |  | Child  Partner |  | | Neighbour/friend  Family | | |  |

|  |  |  |  |  |  |  |  |
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| **3. Client details** | | | | | | | |
| *(If self-referral and details of client are above then please state this)* | | | | | | | |
| **Title** | | Mr  Mrs  Miss  Ms  Dr  Other …………. | | | | | |
| **Name** | |  | | | | | |
| **Prefers to be called** | |  | | | | | |
| **Address inc. postcode** | |  | | | | | |
| **DOB** | |  | | | | | |
| **Tel no** | |  | | | | | |
| **Email** | |  | | | | | |
|  | | | | | **YES** | **NO** | |
| **Is client happy for information about the service to be sent to this email account?** | | | | |  |  | |
| **GP surgery** | | | | |  |  | |
| **NHS no** | | | | | | | |
| **4 What’s prompted this referral.** | | | | | | |
|  |  | |  |  | | |
| **5. Consent** | | | | | | | | |
|  | | | | | **YES** | **NO** | | |
| **Permission to refer, consent by Telephone** | | | | |  |  | | |
| **Is the client aware this referral has been made?** | | | | |  |  | | |
| **Consent given by Client** | | | | |  |  | | |
| **6. What is important for the client at the moment?** | | | | | | | | | |
|  | | | | | | | | | |

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| **7. Additional notes** |
| Is there anything about the client’s illness or anything significant you think we should know about e.g.  Communication needs (hearing, speech, preferred language), learning difficulties. |