Saint Catherine's Palcall Registration Form
CONFIDENTIAL

Patient Details *(or hospital sticker)*

Surname:	**NHS Number:**
Forename:	**Next of Kin Full Name:**
Date of Birth:	**Relationship:**
Sex:	
Address:	**Address:**
Postcode:	**Postcode:**
Key Safe Number (if appropriate):	**Phone No:**
Phone No:	**Mobile No:**
Mobile No:	
Ethnic Group:	**Main Carer:**
Main Language:	
Religion:	**Phone No:**

GP Name:	Key HCP/Care Manager:
GP Practice:	Phone No:
Phone No:	

Clinical Details

Main Diagnosis:

Complications/secondary diagnosis

Is the patient aware of diagnosis?

Special Notes :

Does patient have a preference for place of care? (state where):

Does patient have a preference for place of death?(state where):

Is there a DNAR form in place? **Yes** **No**
If YES, is it with the patient? **Yes** **No**

Clinical Details Cont:

Patient Name: **DOB:**

Failed Drugs:
Drug Hypersensitivity:
Are the 4 key drugs prescribed?
Is there a syringe driver in situ?
Is the patient catheterised?
Does the patient live alone? Relevant home information:
Does the patient have an advance care plan or best interest decision?

Please include a list of current medication if available:

Referrer Print Name:

Referrer Sign Name:

Designation:

Date:

The appropriate referral form must also be completed for each hospice service you are referring the patient to - ie Care Homes Support Team, Hospice at Home Team