MACMILLAN CANCER SUPPORT

Manchester Local Care Organisation
Leading local care, improving lives in Manchester, with you

Manchester Macmillan Supportive and Palliative Care Service

Adult Referral Form

IF YOUR REFERRAL IS URGENT PLEASE CONTACT THE OFFICE

PATIENT DETAILS	**Gender** Male / Female / Other **Civil Status;**	**Ethnic Status** – please tick
Surname …….. First Name ……..…. Known as ……..… Address …… …… …….. Post Code …… Telephone …… NHS number. ..... Date of Birth ……	Married/Separated ☐ Civil Partnership ☐ Single ☐ Widowed ☐ Divorced ☐ Cohabiting ☐ Occupation (or last occupation) …….. Lives alone Yes/No	White British ☐ Black Caribbean ☐ White Irish ☐ Black African ☐ Other white ☐ Other Black ☐ Indian ☐ Chinese ☐ Pakistani ☐ Other ☐ Bangladeshi ☐ Not stated ☐ Other Asian ☐ Mixed white/black Caribbean ☐ Mixed white/black African ☐ Mixed white/Asian ☐ Other mixed ☐ Language..... Is interpreter required; Yes/No Religion ……..……

Does the patient consent to the referral? Yes / No
Is the patient's next of kin aware of the referral? Yes / No
Has the patient given consent for their information to be shared? Yes / No

NEXT OF KIN DETAILS	**GENERAL PRACTITIONER**	**REFERRER DETAILS**
Surname …… Name ……..…… Relationship …….. Address……..….. ….……..….. ……..…… Post Code ……..…… Telephone ……	Name ……..….. Practice…… Address…… …….. Post Code ……..… Telephone ……..… Fax…… NHS.Net Email …….. GP aware of referral: Yes/No	Name …… Designation ...……..….. Department …… Address …… ……..…… Post Code ……..…… Telephone.....……..……..…… Fax……..…..……..…… NHS.Net Email ……..……..

Diagnosis (e.g. Primary and secondary cancer, non-malignant disease)

Date(s) of diagnosis:
Is patient aware of their diagnosis? Yes / No
Is the patient aware of their prognosis? Yes / No

PLEASE SEND COPIES OF RELEVENT CLINICAL CORRESPONDENCE WITH THIS FORM

Current Services Involved	Name	Base	Telephone No.

Current Problems					
1.Activities of daily living		9. Exercise rehabilitation		17. Nutrition	
2. Assessment		10. Family support & advice		18. Pain & Symptom Management	
3. Bereavement support		11. Fatigue		19. Palliative Care	
4. Body Image		12. Goal setting		20. Psychological Support	
5. Breathlessness		13. Indirect contact/advice		21. Respiratory	
6. Speech & Voice		14. Lymphoedema		22. Stress/anxiety management	
7. Dysphagia		15 Mobility		23. Supportive D/C	
8. End of Life Care		16. Moving and Handling		24. Vocational	

CURRENT MEDICATION + ALLERGIES

PAST MEDICAL HISTORY

Has the patient been fitted with:
a) A cardiac pacemaker/ implanted defibrillator? YES/NO
b) Radioactive or other implant? YES/NO

SOCIAL SITUATION
e.g. housing, family, financial

Please tick box if following has been discussed/is in place

Palliative Care Register	☐	Six Steps register	☐	Anticipatory Drugs	☐
Do Not Attempt Resuscitation	☐	Statement of Intent	☐	Preferred Priorities Care	☐
Living Will/Advance Directive	☐	Power of Attorney (Health & Welfare)	☐	Power of Attorney (Property & Financial)	☐

CHC applied for Yes /No Date submitted:

RESPECT form/Advanced Care Plan/DNAR Yes/No

Please clearly state what the priorities are for the first visit including information of any screening tool (MUST, Pain Assessment etc) and treatments carried out.

Referrers Signature: **Date of Referral:**

PLEASE SEND REFERRALS TO:

North Hub: 0161 470 6719 / 0161 223 9393 **Central Hub**: 0161 248 1252 **South Hub (SPA):** 0300 303 9650

pah-tr.Community-Macmillan-Service@nhs.net mft.centralcommunitymacmillan@nhs.net mft.spa-uhsm@nhs.net