REFERRAL TO COMMUNITY MACMILLAN TEAM

Please complete clearly and in full to allow appropriate specialist intervention.

Please fax forms to **01384 321524** or email**: macmillanspecialistteam@nhs.net**

<table>
<tr><td colspan="3">Is patient aware of and consented to Macmillan referral? Yes No</td></tr>
<tr><td colspan="3">Date Referral Made:</td></tr>
<tr><td>Patient Name:
NHS No:</td><td>DOB:</td><td>Age:</td></tr>
<tr><td rowspan="2">Address: (or affix patient label)</td><td colspan="2">Telephone No:

Mobile No:</td></tr>
<tr><td colspan="2">Temporary Address if different</td></tr>
<tr><td>Next of Kin:

Main Carer: Yes / No</td><td colspan="2">Contact No:</td></tr>
<tr><td rowspan="2">Diagnosis:

Written Letter Confirming Diagnosis Yes No
Is patient aware of Diagnosis Yes No</td><td colspan="2">Prognosis:</td></tr>
<tr><td colspan="2">Is the pt receiving chemo/DXR
Yes No
If yes – up and coming treatment dates:</td></tr>
<tr><td rowspan="2">Current Patient Medication:</td><td colspan="2" rowspan="2">Current other Professional’s Involved and contact details(e.g. DN’s)</td></tr>
<tr><td>Known Allergies:</td></tr>
<tr><td>Other co-morbidities:</td><td colspan="2">Reduced Renal Function Yes / No

If Yes- please provide latest EGFR:</td></tr>
<tr><td>Patient’s GP:

Address:

Telephone:</td><td colspan="2">Patient’s Consultant:

Hospital:</td></tr>
</table>

Reason for Referral	Type of Specialist intervention required by the Macmillan Team
Symptom Control **(e.g. pain, N&V, terminal agititation)**	
Psychosocial Support / Spiritual Support	
Functional Deterioration	
End of Life Planning (DNAR / PPC / ACP)	
Advice re Treatment Options	

Please tick where you think the patient should be seen:-

CLINIC SETTING	**HOME**

Referrer Name: Please Print:	Designation:
Referrer Contact Details: Phone: Fax: Nhsnet:	Date patient last seen by yourself:

FOR ALL HOSPITAL DISCHARGES PLEASE PROVIDE DISCHARGE FORMS

FOR ALL GP REFERRALS PLEASE PROVIDE PATIENT SUMMARY