This is a support service provided by the Wellbeing Network at Herriot Hospice Homecare and Saint Michael’s Hospice. Referrals can be made for patients, families, and carers over the age of 18, affected by terminal illness.

**Please mark the box to indicate that consent has been given by the client and Next of Kin (NOK) for their personal information to be processed and stored by the Wellbeing Team** [ ]

**Date and time of consent:**

|  |
| --- |
| **Client Details** |
| **Name:** |       | **Date of Birth:** |       |
| **Preferred Name:** |       | **Age:** |       |
| **Ethnic origin:** | Choose an item. | **Religion:** |       |
| **Gender:** | Choose an item. | **Sexual orientation:** | Choose an item. |
| **Diagnosis:** |       | **Support Required:** | Choose an item. |
| **Relationship to Patient** | Choose an item. |  |
| **Are there any communication difficulties, disabilities or other conditions the service should be aware of?** |
| [ ]  Yes [ ]  No |
| **If yes, please specify:** |  |
| **Contact Details and Communication Preferences** |
| **Address/Postcode** |       | **Email Address:** |       |
| **Tel No (Home):** |       | **Tel No (Mobile):** |       |
| **Do You Consent to Being Contacted Via:**[ ]  Email [ ]  Text [ ]  Letter |
| **Next Of Kin (NOK) Details** |
| **Name:** |       | **Contact Number** |       |
| **Address/Postcode:** |       | **Does the NOK have LPOA?** | Choose an item. |

|  |
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| **Other Agencies Involved in Your Care/Support** |
| **GP Name/Surgery:** |       |
| **Telephone Number:** |       |
| **Referrers Details** |
| **Referrer Name/Job Title:** |       | **Tel No:** |       |
| **Organisation address:** |       | **Email:** |       |
| **Referral Details** |
| **Date of Referral:** |       | **Known to SMH/HHH:**  | [ ]  Yes [ ]  No |
| **Does the Patient have a DNA CPR?** | Choose an item. |  |
| **Reasons for Referral**(Please provide as much information as possible)      |

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