St Michael's Hospice

LIVING WELL SERVICE REFERRAL FORM

Please send completed form to smhadmin@hhft.nhs.uk
If you have any queries, please call 01256 848863

FIRST NAME:	**SURNAME:**
D.O.B:	**NHS No:**

<table>
<tr><th colspan="3">ADDITIONAL DETAILS</th></tr>
<tr><td>Address:</td><td colspan="2"></td></tr>
<tr><td>Contact Number:</td><td colspan="2"></td></tr>
<tr><td>NOK:</td><td>Name:

Contact number:</td><td>Relationship to patient:</td></tr>
<tr><td></td><td>GP:</td><td>Surgery:</td></tr>
<tr><td>Patient aware of referral?</td><td colspan="2">Yes ☐ No ☐
If no, please state why</td></tr>
</table>

DETAILS FOR REFERRAL (please give as much information as possible)
Diagnosis: (including when diagnosis was received and patient's understanding of their diagnosis) **Relevant previous medical history:**

St Michael's Hospice

Mobility:

Independent
Yes ☐ No ☐

Uses aid
Yes ☐ No ☐
If yes, what aid ____

Wheelchair
Yes ☐ No ☐

Oxygen:
Yes ☐ No ☐

Reason for Referral:
(please give as much detail as possible how our Living Well Service can help)

Services Requested: (please see https://www.stmichaelshospice.org.uk/our-care/living-well-service/ for more details)

☐ Living Well Together
☐ Living Well with Your Symptoms
☐ Living Well Actively
☐ Living Well, Living Better (social group)
☐ Men's Group
☐ St Bernard Support (financial support)

Referred by:

Job Title:

Email address:

Contact number:

Date of referral:

LIVING WELL SERVICE USE ONLY	
Allocated to	
Date	
Initial Contact Made	
Group Attending	
Start Date	