

Freshwinds

Integrated Complementary Outreach Project

Referral Guidelines



ACCESS TO THE SERVICE

This service is designed entirely for adult patients requiring palliative care and are not well enough to travel to Freshwinds. Patients need to be under the care of a BEN PCT or HoB PCT GP.

Although clients can self-refer, it is preferable that a relevant health worker or doctor makes the referral. Referral forms are available on-line at www.freshwinds.org.uk or by contacting Freshwinds. Where appropriate, limited support is also available to the carer or family. In the event that the client self-refers they will be required to complete an application form and provide a letter of diagnosis from their health worker or doctor.

On receipt of the referral, the client will be contacted to arrange an assessment by a Freshwinds outreach assessor. Following this, and in consultation with a Freshwinds medical officer, a plan will be made and the delivery complementary therapies will start. Where necessary, information and advocacy services will also be offered to deal with other social and financial difficulties faced by the client, their carer or family.

The Client's GP as well as the relevant health worker or doctor who makes the referral will receive a letter of information regarding the assessment and the services to be provided. Depending on the needs of the client, the therapies being offered will be reviewed from time to time by Freshwinds, and changes made accordingly.

To ensure that the assessment is comprehensive and relevant to the client's needs, the medical officer and outreach team need to be able to have as much information as possible. This can include copies of any reports or investigations, as well as planned treatments.

For any other information please contact Freshwinds on
Tel: 0121 415 6670 Fax: 0121 415 6699

Freshwinds, Prospect Hall, 12 College Walk, Selly Oak, Birmingham, B29 6LE
e-mail: dr.lee@freshwinds.org.uk dr.shah@freshwinds.org.uk

Web: www.freshwinds.org.uk



Freshwinds – Integrated Medicine Referral Form

PLEASE WRITE CLEARLY IN BLACK INK

Please indicate which project you are referring to:

- In-House Integrated Medicine services
- Living Choices*: Complementary Therapy Outreach Project

A. Referring Person

Name			
Post			
Organisation			
Address			
	Post code		
Telephone No:		Fax No:	
E-mail			

B. Patient's Details

Full Name			
Date of Birth	Age:	Gender: Male <input type="radio"/> Female <input type="radio"/>	
Address			
	Post Code		
Telephone No		Fax No:	
Ethnic Group	Main Language:		
NHS number	Marital Status:		
Occupation			

C. Main Carer's Details

Name			
Relationship			
Telephone			

D. GP Details

Name			
Address			
	Post Code:		
Telephone			
Fax			

E. Hospital Details

Hospital			
Consultant			

Please indicate what services are requested (please tick all appropriate boxes)

- Integrated Complementary Therapy service
- Information, Advice and Advocacy support
- Carer Support

F. Other Professionals Involved

Please tick all that apply and give details:

	Name	Contact / Tel no
District Nurse <input type="checkbox"/>		
Hospital Palliative care nurse <input type="checkbox"/>		
Other Specialist nurse <input type="checkbox"/>		
Occupational therapist <input type="checkbox"/>		
Physiotherapist <input type="checkbox"/>		
Dietician <input type="checkbox"/>		
Social Worker <input type="checkbox"/>		
Other <input type="checkbox"/>		

G. Reasons for Referral

We would be grateful for any additional information e.g. copy of clinic letters etc would help to speed up the time to set up service within the patient's home.

Diagnosis (Date & Details)
Histopathology (if appropriate)
Date and Details of Treatments received

Please list any other of the patient's past or existing medical conditions

H. Main Symptoms

Please tick all that apply:

Pain	<input type="checkbox"/>	Dyspnoea/Shortness of Breath	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Lack of energy/fatigue	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Confusion	<input type="checkbox"/>
Dysphagia	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	Skin conditions	<input type="checkbox"/>

Others:

Details of patient's current therapeutic and psychological care needs:

Please give a brief description of the patient's level of mobility:

I. Medication

J. Allergies

K. Prognosis

Please give details of the patient's prognosis

Is the patient aware of their prognosis? Yes No

(If not then please expand)

Have you included any additional information with this referral? Yes No

Signature of Referrer: _____

Date: _____

Please send this form to us at our address or by fax:

Post: Freshwinds, Prospect Hall, 12 College Walk, Selly Oak, Birmingham, B29 6LE

Fax: 0121 415 6699