Pennine Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS
NHS Trust

Version v1.0 October 2017

District Nurse/Treatment Room Service Referral Form

Patient's Name:	DOB:
Address:	
NHS Number:	NOK:
Patient's Contact Number:	Can Patient Attend Treatment Room? YES / NO
Interpreter Needed: YES / NO	1st Language:
Date of Admission:	Date of Discharge:

Name of Referrer:	Date:
Hospital/Ward:	Contact Number:
GP: Address: GP Tel Number:	
Date 1st visit required:	Allergies:
Diagnosis/Reason for referral:	Dressing type: …… Please change dressing in: ……. Days Remove sutures in: ……. Days Plaster check Other:
Discharge medication with patient: YES / NO	If NO please comment:

Date	Name and Strength of Drug	Dose	Time required	Route	Duration	Prescriber Name	Prescriber Signature

Are there any known risks: YES/NO If YES please contact District Nurse	Access problems?:
Any other information I.e. SAFEGUARDING	

HMR	BURY	OLDHAM	NORTH MANCHESTER
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