FAX NUMBERS: HMR LIAISON: 01706 676365 BURY ABC: 0300 323 3321 OLDHAM SPA: 0161 785 8951

Pennine Care NHS
NHS Foundation Trust

REFERRAL FORM FOR DISTRICT NURSES/TREATMENT ROOM SERVICE

HOME VISITS WILL ONLY BE ACCEPTED FOR HOUSEBOUND PATIENTS

PATIENTS NAME:		DOB:	NAME OF REFERRER:	DESIGNATION:	DATE:
ADDRESS:			HOSP/WARD:		TELEPHONE NUMBER:
NHS NUMBER:		NOK INFORMATION:	GP: DR ADDRESS:		
PATIENT CONTACT NUMBER:		CAN PATIENT ATTEND TREATMENT ROOM? **YES / NO**	GP TEL NUMBER:		
INTERPRETER NEEDED **YES / NO**		1ST LANGUAGE:	DISTRICT NURSE TEAM:		
DATE OF ADMISSION:		DATE OF DISCHARGE:	DATE 1ST VISIT REQUIRED:		ALLERGIES:
DIAGNOSIS/REASON FOR REFERRAL:					DISCHARGE MEDICATION WITH PATIENT YES / NO IF NO PLEASE COMMENT:

DATE	NAME AND STRENGTH OF DRUG	DOSE	DOSE TIME	ROUTE	DURATION	PRESCRIBER PRINT & SIGN	

ARE THERE ANY KNOWN RISKS **YES / NO** IF YES PLEASE CONTACT DISTRICT NURSE	ACCESS PROBLEMS:
ANY OTHER INFORMATION ie. SAFEGUARDING:	

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REFERRAL FORM FOR DISTRICT NURSES/TREATMENT ROOM SERVICE
CONTINUATION SHEET

PATIENT NAME:	DATE OF BIRTH:	NHS NUMBER:
ADDITIONAL COMMENTS:		