

Chief Executive  
Sr Rita Dawson  
Director of Medical Services  
Prof. Marie Fallon

Medical Team  
Prof J Welsh  
Dr Colin Barrett  
Dr Guy Haworth  
Dr Alisdair Campbell

**REFERRAL FORM**  
**ST MARGARET OF SCOTLAND HOSPICE**

EAST BARNES STREET • CLYDEBANK • G81 1EG  
TELEPHONE 0141 952 1141 • FAX 0141 951 4206  
Email: [office@smh.org.uk](mailto:office@smh.org.uk)



**REFERRAL FOR:**

DAY REHABILITATION UNIT/  
OUT-PATIENT CLINIC       BEREAVEMENT SUPPORT       COMMUNITY PALLIATIVE CARE TEAM

IN-PATIENT ADMISSION

SYMPTOM CONTROL       END OF LIFE CARE       RESPITE CARE (FROM HOME ONLY)

PATIENT DETAILS:

SURNAME: ..... FORENAME: ..... CHI: .....

ADDRESS: ..... TELEPHONE NUMBER: .....  
..... POSTCODE: .....

DATE OF BIRTH: ..... MARTIAL STATUS: ..... RELIGION: .....

NEXT OF KIN:

NAME: ..... RELATIONSHIP: .....

ADDRESS: ..... TELEPHONE NUMBER: .....  
..... POSTCODE: .....

GENERAL PRACTITIONER:

NAME: .....

ADDRESS: ..... TELEPHONE NUMBER: .....  
..... POSTCODE: .....

**IF REFERRING FROM HOSPITAL:**

CONSULTANT: ..... HOSPITAL: ..... WARD: .....

TELEPHONE NUMBER: ..... IS GP AWARE OF REFERRAL: YES/NO

<b>IS THE PATIENT:</b>		<b>DOES THE PATIENT HAVE:</b>	
AWARE OF THE REFERRAL	YES/NO	A PACEMAKER	YES/NO
AWARE OF THE DIAGNOSIS	YES/NO	AN IMPLANT	YES/NO
AWARE OF THE PROGNOSIS	YES/NO	ANY ALLERGIES	YES/NO
DOES THE PATIENT HAVE ANY INFECTION WHICH WOULD REQUIRE A SINGLE ROOM			YES/NO

DIAGNOSIS: ..... DATE OF DIAGNOSIS: .....

KNOWN METASTASES: ..... HISTOLOGY: .....

EXACT SITE OF PRIMARY TUMOUR: .....

ESTIMATED PROGNOSIS: ..... DAYS/WEEKS/MONTHS

