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**Tel No: 0116 231 3771**

**REFERRAL FORM – to LOROS (not for Inpatient admission)**

**This referral form should only be used by UHL and Rainbows Hospice and can be sent securely from a UHL or NHS.net email account to the relevant LOROS service email address (see below).**

**For referrals for admission to LOROS, the UHL palliative care team can complete the Ward Referral form or ring 0116 2313771.**

**Specialist Palliative Care Nurse (Community) referrals should be sent to** **llr.icspc@nhs.net**

**Telephone No. 0300 5555 255 8.30am-7.30pm**

**Outpatients and MDT Breathlessness Clinic**: loros.outpatient@nhs.net

**Day Therapy:** [loros.day\_therapy@nhs.net](loros.day_therapy%40nhs.net)

**Counselling:** [loros.counselling@nhs.net](loros.counselling%40nhs.net)

**Compassionate Neighbours:** [loros.compassionateneighbours@nhs.net](loros.compassionateneighbours%40nhs.net)

**Doctors Domiciliary Visits:** [loros.domiciliary@nhs.net](loros.domiciliary%40nhs.net)

**Lymphoedema:** loros.lymphoedema@nhs.net

**Young Persons and Transition:** loros.young\_persons\_and\_Transition@nhs.net

**For more information about the services that we offer please visit our website:**

[**https://www.loros.co.uk/healthcare-professionals/referral-guidance/**](https://www.loros.co.uk/healthcare-professionals/referral-guidance/)

**BLOCK CAPITALS (if handwritten please)**

**Please complete all fields and provide as much information as possible.**

**Please ensure patient agrees to the referral.**

Patient Name

NHS Number (compulsory) ………………………………… Date of Birth ……………………………………

Referrer’s Name ………………………… Referrer’s designation…………………………………

Referrer’s department/ward……………………………………………………………………………..

Referrer’s Tel No……………………………………………………………........

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| --- |
| **Diagnosis and relevant history** |

|  |
| --- |
| **Relevant past medical history & other important information** (or attach a separate letter)**Key Problems to be addressed** |

**What the patient’s communication needs?**

|  |  |
| --- | --- |
|  |[ ]  No communication issues |
|  |[ ]  Interpreter needed – Language ………………………………………. |
| **Communication difficulties** |[ ]  Impaired vision󠄀 |
|  |[ ]  Hearing difficulty |
|  |[ ]  Learning difficulties |
|  |[ ]  Difficulty using verbal communication |
| **Communication needs** |  |  |
|  |[ ]  Facing the client when communicating |
|  |[ ]  Requires slow verbal communication |
|  |[ ]  Requires loud verbal communication |
|  |[ ]  Requires contact by email |
|  |[ ]  Requires contact by letter |
|  |[ ]  Requires contact by telephone |
|  |[ ]  Requires written information in large font |
|  |[ ]  Requires communication partner |
|  |[ ]  Uses British sign language |
|  |[ ]  Requires information in Easy read |
|  |[ ]  Reads Braille |