

# CLINICAL REFERRAL FORM

Please complete **all fields**, print, sign and then fax to Bupa Home Healthcare.

**This referral form will not be processed unless it is completed in full and accompanied by a valid prescription.**

**Please post original copy to:** Bupa Home Healthcare (Oncology service), Scimitar Park, Roydon Road, Harlow, Essex CM19 5GU

Fax: 0845 8888 368 or 01279 456717 Tel: 0800 082 5021

## PATIENT DETAILS

|                                  |                                                         |
|----------------------------------|---------------------------------------------------------|
| First name Mr/Mrs/Ms/Miss/Master |                                                         |
| Surname                          |                                                         |
| Date of birth                    | Male <input type="radio"/> Female <input type="radio"/> |
| Address                          |                                                         |
| Postcode                         |                                                         |
| Telephone                        | Mobile                                                  |
| Email address                    |                                                         |
| NHS number                       |                                                         |
| Hospital number                  |                                                         |

|                   |
|-------------------|
| Diagnosis         |
| Date of diagnosis |

## REFERRING HOSPITAL

|                   |           |
|-------------------|-----------|
| Hospital          |           |
| Address           |           |
| Postcode          |           |
| Telephone         |           |
| <b>Consultant</b> |           |
| Telephone         | Ext/bleep |
| Email             | Fax       |
| <b>Pharmacist</b> |           |
| Telephone         | Ext/bleep |

|                              |
|------------------------------|
| <i>For internal use only</i> |
| Bupa pre-authorisation code  |

## TREATMENT PLAN

|                                                    |                                                                                                                                               |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Proposed treatment plan                            | 1st line treatment? YES <input type="radio"/> NO <input type="radio"/>                                                                        |
|                                                    | 1st cycle given in hospital YES <input type="radio"/> NO <input type="radio"/>                                                                |
|                                                    | Commencement date (by Bupa)                                                                                                                   |
|                                                    | 2nd <input type="radio"/> 3rd <input type="radio"/> 4th <input type="radio"/> 5th <input type="radio"/> line treatment? (tick as appropriate) |
| Please give details of previous treatment regimes: | Please give details of any previous adverse reactions/hypersensitivity                                                                        |
|                                                    |                                                                                                                                               |
|                                                    |                                                                                                                                               |

## VENOUS ACCESS

|                                                |                                                    |
|------------------------------------------------|----------------------------------------------------|
| Peripheral access (please tick as appropriate) | YES <input type="radio"/> NO <input type="radio"/> |
| Axillary node clearance                        | YES <input type="radio"/> NO <input type="radio"/> |
| Conditions of veins                            |                                                    |
| CVAD (please tick as appropriate)              | YES <input type="radio"/> NO <input type="radio"/> |
| Type of CVAD                                   |                                                    |

## BLOODS

|                                               |                                                    |
|-----------------------------------------------|----------------------------------------------------|
| Pre/post treatment bloods to be taken by Bupa | YES <input type="radio"/> NO <input type="radio"/> |
| Request date for 1st blood test:              |                                                    |
| Blood forms supplied                          | YES <input type="radio"/> NO <input type="radio"/> |
| Blood request (eg FBC, U&E, LFT, CRT, CEA)    | YES <input type="radio"/> NO <input type="radio"/> |

### Patient consent - to be signed by the patient/parent/guardian

Under the provisions of the Data Protection Act 1998, Bupa Home Healthcare need your consent to keep and use information about you and your health on their computer systems. Please read the following statements and confirm your agreement. I confirm my agreement for Bupa Home Healthcare to hold, update and use my information for the purpose of providing, monitoring and improving a home delivery service. I understand that the information they hold may include personal identification data (name, address, telephone number etc), details of my medical condition and medication prescribed to me. I understand that from time to time this information may be provided to other organisations involved in my home care but will always be in a form that does not identify me personally. I understand that I have rights to gain access to and to correct this information.

|        |      |
|--------|------|
| Name   |      |
| Signed | Date |

### To be completed by the referring clinician (if the patient is unable to sign)

I have fully explained and discussed the home care service with the patient and he/she has given their explicit informed consent to receive this service from Bupa Home Healthcare. The patient understands and consents to his/her personal and health information being passed to and processed by Bupa Home Healthcare, under the provisions of the Data Protection Act 1998, in order for the home care service to be provided to them.

|                                                                 |      |
|-----------------------------------------------------------------|------|
| <b>Health professional signature (on behalf of the patient)</b> |      |
| Name                                                            |      |
| Signed                                                          | Date |