Freshwinds: Integrated Medicine Project
Referral Guidelines for Health Professionals

Following are the various services offered by the project. Depending on the aims of the service there are specific entry criteria that are required.

In-House Services: Eligibility

1. Adults living with life-threatening conditions, e.g. cancer, HIV, MS and others.
2. Children living with life-threatening and life-limiting conditions.
3. No geographical boundaries.

Referral to the project can be done by Health Professionals. Individual clients can self-refer by requesting us for an application pack, but they will still need a supporting letter/proof of diagnosis.

Should you require any further information then please contact us on: 0121 415 6670

Freshwinds – Integrated Medicine Referral Form

Please write clearly in black ink

Please indicate clearly which project you are referring to:					
In-House – Integrated Medicine Services				○	
A.	**Referring Person**				
	Name				
	Post				
	Organisation				
	Address				
		Post Code:			
	Telephone No.				
	Email				
B.	**Patient's Details**				
	Full Name				
	Date of Birth		**Age**		**Male ○ Female ○**
	Address				
		Post Code:			
	Telephone No.				
	Email				
	Ethnicity		**Main Language**		
	Occupation		**Marital Status**		
	Is the patient on the GSF register?		**Yes ○ No ○**		
C.	**Main Carer's Details**				
	Name		**Relationship**		
	Telephone No.				
D.	**GP Details**				
	Name				
	Address				
		Post Code:			
	Telephone No.				
	Email Address				
	Fax No.				
E.	**Hospital Details**				
	Hospital	**City ○ QE ○ Good Hope ○ Heartlands ○ Other ○**			
	Consultant				
	Speciality				
FOR OFFICE USE					
Cross City CCG ○ South And City CCG ○ Sandwell and West Midlands CCG ○					

Please indicate what other services are required *(please tick all appropriate boxes)*:	
Information, Advice and Advocacy Support	○
Carer Support	○

F.	**Other Professionals Involved**	
	Name	**Organisation**
District Nurse		
Hospice Nurse		
Specialist Nurse		
Other		

G.	**Reasons for Referral**

Please provide any additional information e.g. copies of clinic letters etc. These will help to expedite the time it may take to set up the service at the patient's home.

Diagnosis (date and details)

Histopathology (if appropriate)

Treatments Received (date and details)

List any other past or existing medical conditions

H.	**Main Symptoms** (tick all that apply):

Pain ○	**Dyspnoea/Shortness of breath** ○	**Anxiety** ○
Anorexia ○	**Cough** ○	**Difficulty sleeping** ○
Constipation ○	**Weakness** ○	**Lack of energy/Fatigue** ○
Diarrhoea ○	**Depression** ○	**Confusion** ○
Dysphagia ○	**Nausea/Vomiting** ○	**Skin conditions**

Other:

Details of patient's current therapeutic and psychological care needs

Please give a brief description of patient's level of mobility

Independent/Mobile ○	**Uses a walking stick** ○	**Uses a walking frame** ○
Uses wheelchair ○	**Confined to bed** ○	

Other:

I.	**Allergies**

None known ○ **Yes** ○ (please provide details)

J.	**Medication** (please provide detail of all medication)

K.	**Prognosis** (please provide detail of patient's prognosis)

Is the patient aware of their prognosis?	**Yes** ○	**No** ○

L.	**Preferred place of care** (if known)

First choice	**Second choice**
Home ○ **Hospice** ○ **Hospital** ○ **Other** _____	**Home** ○ **Hospice** ○ **Hospital** ○ **Other** _____

M.	**Other information** (if known)	
Does the patient have a Personalised Budget?	**Yes** ○	**No** ○
Does the patient access Direct Payments?	**Yes** ○	**No** ○

Have you included any additional information with this referral?	**Yes** ○	**No** ○

Signature of referrer: _____

Date: _____

Please return to:

By Post: Freshwinds, Prospect Hall, 12 College Walk, Selly Oak, Birmingham B29 6LE

Fax: 0121 415 6699

Email: Linette.Tatton-Brown@freshwinds.org.uk