LEWIS-MANNING HOSPICE
BREATHING CLINIC REFERRAL FORM

Post to: Breathing Clinic, Lewis-Manning Hospice, 1 Crichel Mount Road, Lilliput, Poole, Dorset, BH14 8LT
Fax to: 01202 701890
This referral form can be downloaded from the website: www.lewis-manning.co.uk

1. ESSENTIAL PATIENT INFORMATION		
Patients Name	**Patients Address with Post Code**	**Telephone Number:**
Date of Birth:		**Patient aware of referral:** **Yes** **No**

2. REFERRED BY		
Name and position	**Contact number**	**Signature & Date**

3. PATIENT'S GP AND SURGERY	**4. OTHERS INVOLVED** (name and phone number where possible)
Telephone No: **GP aware of referral Yes No**	• **Hospital Consultant(s)** • **District Nurses** • **Specialist Nurses**

5. DIAGNOSIS	**Patient Aware Yes No** **Relatives aware Yes No**

Date of diagnosis
Other underlying pathology
Treatment Received and Dates:
Surgery
DXT
Chemotherapy
Other
Medication
Date of last chest x-ray
Reason for Referral
Other comments:
Signature: