YORKSHIRE AMBULANCE SERVICE GP OUT OF HOURS
PALLIATIVE CARE HANDOVER FORM Fax To: 01904 621406

Patient details	**Carer's details**
Name: DOB: Address: Postcode: Tel no (inc code):	Name: DOB: Address: Postcode: Tel no (inc code):

Medical Condition
Diagnosis (with date)

Complicating Factors

Patient and carers' understanding/insight

Any anticipated problems

Preferred place of care if condition deteriorates:

Current Relevant Medication (with doses and routes)

Emergency drugs left in home? Yes ☐ No ☐

If yes, details:

Professionals involved

DN Yes ☐ No ☐ Name:

Macmillan nurse
Hospital Team
Hospice

Patient' s GP

Do you wish to be contacted if patient phones GP OOHs Service? Yes ☐ No ☐
If yes, contact details:

Handover Form Completed by: *(Please Print Name)*

Signed: Dated:

Approved by the LMC July 2004