

# Making a Referral to Phyllis Tuckwell

For adult patients registered with a GP in  
Guildford & Waverley, Surrey Heath, NE Hampshire & Farnham

## Patients (18+) with:

- Advanced cancer.
- End stage non-malignant disease.
- Deteriorating health.
- Moderate/severe frailty.
- Terminal/advancing illness.

## Carers and Family Members

with  
one or  
more

## Complexity

- Physical and symptom control needs.
- Psychological and spiritual symptoms.
- Social needs impacting on ability to cope with current health situation.
- Help with advance care planning.
- Help with end of life care discussions and decisions.

## Single Point of Access for Advice & Referrals

For professionals, patients, their carers.

7 days a week, 8am-6pm.

01252 729440

PTH.adviceandreferral@nhs.net

## Out of Hours

after 6pm:  
Calls transferred to the In-Patient Unit for access to nursing and medical advice.

## Rapid Assessment

For urgent referrals with unstable symptoms/rapid deterioration.

By a Clinician with feedback to the usual professional team.

## Living Well Programme

For those earlier in their illness, able to access our Guildford/ Farnham sites:

### Information & Support

A range of support and information services for patients/carers/families.

### Patient Therapies

Supportive programmes based on needs (reviewed with the patient every 6-12 weeks).

A range of therapeutic sessions for groups and individuals promoting physical and emotional wellbeing and quality of life.

### Carer & Family Support

During the illness of the family member/partner/friend, under care of PTHC.

### Bereavement Support

Following death of PTHC patient.

**SEE OVERLEAF**  
for Living Well programme suitable for patients, carers and family members.

## In-Patient unit

For symptom control and terminal care.

7 day/week admissions.

- PTHC Consultants/Drs.
- Nursing.
- Therapists, Counsellors, other members of the MDT.

## Care at Home

Patients with unstable physical symptoms or psychological needs - at home, care home or community hospital.

Patients who are: unstable, deteriorating or dying.

Working in partnership with the GP and Community Nursing teams.

- CNSs aligned to GP Surgeries.
- PTHC Consultants/Drs.
- Hospice Care at Home nursing.
- Therapists, Counsellors, other members of the MDT.