Te Omanga Hospice

Ph: (04) 569 7921

Fax: (04) 569 4354

(Hutt Valley/Wainuiomata/Eastbourne)

Hospice Referral Form

Ph: (04) 801 0006

Fax: (04) 389 5035

(Wellington/Porirua/Kapiti Coast)

Name, address, NHI and contact number **OR** **Patient Information Sticker** **(please check address is the correct discharge address)**	Patient consent to palliative care involvement Yes ❒ No ❒ Has GP been informed about referral? Yes ❒ No ❒ Have you phoned hospice prior to discharge to ensure referral received? Yes ❒ No ❒

Primary Diagnosis: (details over page)

Ethnicity / Iwi :	Other barriers to communication:
First language if not English:	
Is an interpreter needed? Yes ❒ No ❒	

Name of main carer: Address:	**General Practitioner:** Telephone:	**Other current services involved:** District Nurses: Yes ❒ No ❒ Community Cancer nurse: Yes ❒ No ❒ Cancer Society: Yes ❒ No ❒ Social Worker: Yes ❒ No ❒..... Other Hospice: Yes ❒ No ❒..... Interpreter: Yes ❒ No ❒..... Hospital Pall Care Yes ❒ No ❒..... Oncology/haem Yes ❒ No ❒ ..... Other: Yes ❒ No ❒ .....
Telephone: Relationship to patient:	**Does patient live alone?** Yes ❒ No ❒	

Service requested:	**General reason for referral:**	**Patient aware of:**
Community Palliative Care Services ❒ Inpatient Hospice Admission ❒	Symptom management ❒ Psychosocial support ❒ End-of-life care ❒ Respite - urgent ❒ Respite – routine ❒ Carer support ❒ Other	Diagnosis Yes ❒ No ❒ Prognosis Yes ❒ No ❒ Palliative approach Yes ❒ No ❒ **Family aware of:** Diagnosis Yes ❒ No ❒ Prognosis Yes ❒ No ❒ Palliative approach Yes ❒ No ❒

Please fax with referral (the most recent/relevant):			
Hospital specialist correspondence:	Yes ❒	Operation reports:	Yes ❒
Radiology results:	Yes ❒	Documentation confirming diagnosis	Yes ❒
Laboratory results:	Yes ❒		

Patient Name: _____ **NHI:** _____

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Brief history of diagnosis(es) and key treatments:		
Date	**Progression of disease and investigations / management**	**Consultant involved**

Current problems:	
1.	**4.**
2.	**5.**
3.	**Patient Mobility:**
Any other comments / information (including psychosocial or spiritual issues):	

Past Medical and Psychiatric History:	**Current Medication:**
Reasons for stopping/changing any medications:	

Drug allergies / sensitivities: **Yes ❒** **No ❒** (list details below)	

Name of Referrer (please print)	**Signature:**
Job designation:	**Date:**
Consultant/Specialty:	
Ward:	
Contact number:	

IF THIS REFERRAL NEEDS URGENT ATTENTION, ie initial contact within 24 to 48 hrs, PLEASE RING THE HOSPICE DIRECTLY.

Adapted with permission from ADHB and Mercy Hospice by Palliative Care Service, CCDHB, Jan 2011