



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 <input type="checkbox"/> No <input type="checkbox"/>
	Has GP been informed about referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you phoned hospice prior to discharge to ensure referral received? Yes <input type="checkbox"/> No <input type="checkbox"/>

Primary Diagnosis: (details over page)

Ethnicity / Iwi :	Other barriers to communication:
First language if not English:	
Is an interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Name of main carer: Address: Telephone: Relationship to patient:	General Practitioner: Telephone: Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>	Other current services involved: District Nurses: Yes <input type="checkbox"/> No <input type="checkbox"/> Community Cancer nurse: Yes <input type="checkbox"/> No <input type="checkbox"/> Cancer Society: Yes <input type="checkbox"/> No <input type="checkbox"/> Social Worker: Yes <input type="checkbox"/> No <input type="checkbox"/> Other Hospice: Yes <input type="checkbox"/> No <input type="checkbox"/> Interpreter: Yes <input type="checkbox"/> No <input type="checkbox"/> Hospital Pall Care Yes <input type="checkbox"/> No <input type="checkbox"/> Oncology/haem Yes <input type="checkbox"/> No <input type="checkbox"/> Other: Yes <input type="checkbox"/> No <input type="checkbox"/>
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Service requested: Community Palliative Care Services <input type="checkbox"/> Inpatient Hospice Admission <input type="checkbox"/>	General reason for referral: Symptom management <input type="checkbox"/> Psychosocial support <input type="checkbox"/> End-of-life care <input type="checkbox"/> Respite - urgent <input type="checkbox"/> Respite – routine <input type="checkbox"/> Carer support <input type="checkbox"/> Other	Patient aware of: Diagnosis Yes <input type="checkbox"/> No <input type="checkbox"/> Prognosis Yes <input type="checkbox"/> No <input type="checkbox"/> Palliative approach Yes <input type="checkbox"/> No <input type="checkbox"/> Family aware of: Diagnosis Yes <input type="checkbox"/> No <input type="checkbox"/> Prognosis Yes <input type="checkbox"/> No <input type="checkbox"/> Palliative approach Yes <input type="checkbox"/> No <input type="checkbox"/>
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Please fax with referral (the most recent/relevant):

Hospital specialist correspondence: Yes <input type="checkbox"/>	Operation reports: Yes <input type="checkbox"/>
Radiology results: Yes <input type="checkbox"/>	Documentation confirming diagnosis Yes <input type="checkbox"/>
Laboratory results: Yes <input type="checkbox"/>	

Patient Name: _____ NHI: _____

Hospice Referral Form - 2

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 <input type="checkbox"/> No <input type="checkbox"/> (list details below)

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

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