

# HOSPICE & SPECIALIST PALLIATIVE CARE REFERRAL FORM

Hospice Rotorua

PH: 073 436 591 ext1 FAX: 07 347 8377

Post: PO Box 1092, Rotorua 3040  
email: nurses@rotoruahospice.co.nz

Lake Taupo Hospice (includes Turangi)

PH: 07 377 4252 FAX: 07 377 4253

Post: PO Box 950, Taupo 3330  
email: info@laketaupohospice.co.nz

## PERSONAL DETAILS

Patient Sticker may be placed in the box below

ENTRY CRITERIA FOR REFERRAL (NB not all referrals will result in admission to the service)  
**Active, Progressive Advanced Disease with a life limiting prognosis**  YES  NO

The patient agrees to the referral if competent to do so (or a named \_\_\_\_\_ advocate agrees on their behalf)  YES  NO

\* NHI No: | | | | |

\* Title: Mr. / Mrs. / Miss / Ms / Dr

\* Surname: \_\_\_\_\_

\* Given Names: \_\_\_\_\_

\* Preferred Name: \_\_\_\_\_

\* DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ \* Gender: Male Female

\* Ethnicity: \_\_\_\_\_

Country of Birth: \_\_\_\_\_ \* NZ Resident:  Yes  No

\* Language Spoken: \_\_\_\_\_ Interpreter required?  Yes  No

\* Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_

\* Phone: (07) \_\_\_\_\_ Mobile: \_\_\_\_\_

\* Email: \_\_\_\_\_

\* Marital Status: \_\_\_\_\_

## REFERRAL INFORMATION

\* Referral Agency: \_\_\_\_\_

\* Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\* Referral Type: **Routine** **Urgent** (Hospital Rapid Discharge Checklist)

Time frame to be  seen in  24hrs  1-2 days  2-7 days

Expected Date of Discharge from Hospital \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\* Reason For Referral:  
 End Stage Care  Counselling  Symptom Management  
 Consult  Other \_\_\_\_\_

\* Services Already Involved :  
 District Nurses  Iwi Provider  Cancer Society  
 OT  Physio  Home Support  
 Social Worker  Oncology  Maori Health Provider  
 Other: \_\_\_\_\_

## DIAGNOSIS

\* Primary Diagnosis: \_\_\_\_\_ Patient Aware of Diagnosis:  Yes  No

Metastases: Lung / Liver / Brain / Bone / Lymph / Other...

\* Diagnosis Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date Estimated?  Yes  No

Secondary Diagnosis: \_\_\_\_\_

Other Major Diagnosis: \_\_\_\_\_

Diagnosis Type:  
Malignant   
Non-Malignant

## NEXT OF KIN / PRIMARY CARER DETAILS

\* Surname: \_\_\_\_\_

\* Given Name: \_\_\_\_\_

\* Relationship to Patient: \_\_\_\_\_

\* Address: \_\_\_\_\_  
\_\_\_\_\_ Post Code \_\_\_\_\_

\* Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

EPOA  Yes  No

## MEDICAL DETAILS

Name of GP: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Specialist: \_\_\_\_\_

Speciality: \_\_\_\_\_

Hospital/Practice Name: \_\_\_\_\_

Forthcoming Appointments? \_\_\_\_\_

## ADVANCED CARE PLAN

ACP	In Place <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Copy attached;	Yes <input type="checkbox"/> No <input type="checkbox"/>

## PHARMACY DETAILS:

Facility name: \_\_\_\_\_

Contact name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Well Being / Te Whare Tapa Wha

Taha Tinana / Physical Well-being; current status and concerns. E.g. mobility, elimination, pain management etc

**MEDICATIONS: ATTACH CURRENT SUMMARY or list below**

Allergies/adverse reactions:  Yes  No

**SYRINGE DRIVER DUE** \_\_\_\_\_

Current Medication

**Infection Control Alerts ? eg MRSA, Hepatitis**

**Wound/ Drain Site & Type:**

Wound Care plan attached:  Yes  No

### EQUIPMENT

OT seen & assessed  Yes Who? \_\_\_\_\_  No

Physio seen & assessed  Yes Who? \_\_\_\_\_  No

Community referrals for OT & Physio made  Yes Who? \_\_\_\_\_  No

**Equipment Required & Provider Agreed**  Yes  No

Shower stool  Super stroller  Lazyboy

Electric Bed  Other:

Oxygen Prescribed By \_\_\_\_\_ Supplied By \_\_\_\_\_

O2 prescription attached: Yes  No

Taha Wairau / Spiritual Well-being; current status and concerns e.g. hopes, plans, faith, what brings meaning to life etc.

Taha Whanau / Social Well-being; current status and concerns, e.g. who provides support, carers wellbeing etc.

Lives Alone  Yes  No

With Spouse /Partner  Yes  No

With Family/Whanau  Yes  No

Taha Hinengaro / Emotional Well-being; current status and concerns e.g behaviours and cognitive functionality etc.

**KNOWN RISKS eg Drugs, Alcohol, Family Violence etc, describe please.**

Name and Designation of Referrer: *(Please Print)* \_\_\_\_\_

Signature of Referrer: \_\_\_\_\_ DATE \_\_\_\_\_

Office Use Only

Entered into PalCare By: \_\_\_\_\_

Date \_\_\_\_\_

Rotorua Community & Lake Taupo Hospices

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