ROTORUA HOSPICE REFERRAL FORM

rotorua community hospice trust

Phone the Palliative Care Coordinator for all referrals and fax the form with associated documents e.g. Discharge summaries, syringe driver authority, lab and radiology results etc

Ph: 07 3436591 Post: PO Box 1092

Fax: 07 3478377 Rotorua

PERSONAL DETAILS

Patient Sticker may be placed in the box below

Entry criteria for admission

Does the patient have an active progressive life limiting condition with a life expectancy of 12 months or less? ○Yes ○No

Has the Medical Team had the discussion about palliative care and referral to hospice with the patient and their family/whanau ○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: O Yes O No

*Language Spoken: Interpreter required? O Yes O No

*Address:

Post Code:

*Phone: (07) Mobile:

*Email:

Marital Status:

REFERRAL INFORMATION

*Referral Agency:

*Phone: Fax:

*Referral Type: Routine Urgent

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

Expected Date of Discharge from Hospital / /

* Reason For Referral:

O End Stage Care O Counselling O Symptom Management

O Respite Care O Consult O Other:

* Services Already Involved :

O District Nurses O Cancer Society O Cancer Liaison Nurses

O O T O Physio O Home Support

O Social Worker O Oncology O Maori Health Provider

O Resp Nurse O NASC O Other

DIAGNOSIS

*Primary Diagnosis:

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

*Diagnosis Date: / / Date Estimated? O Yes O No

Secondary Diagnosis:

Other Major Diagnosis:

*Patient Aware of Diagnosis: O Yes O No

Diagnosis Type:

O Malignant

O Non-Malignant Renal

O Non-Malignant Respiratory

O Non-Malignant Neurological

O Non-Malignant Cardiovascular

O Non-Malignant Multiple

CURRENT ISSUES

Physical / Social / Psychosocial / Spiritual

Social:

O Lives Alone O With Family O With Spouse/Partner

O Other Advanced Care Plan O Yes O No

MEDICAL DETAILS

*** GP** Name of GP:

Practice Name:

Phone: Fax:

*** Specialist** Name of Specialist:

Specialty:

Hospital/Practice Name:

NEXT OF KIN / PRIMARY CARER DETAILS

* Surname:

* Given Name:

* Relationship to Patient:

*Address:

Post Code:

*Phone: *Day* (07) *Night* (07)

Mobile:

CURRENT MEDICATIONS

(Please attach Documentation)

ALERTS

Infectious Status:

Allergies:

Other Alert:

* Name of Referrer: *(Please Print)*

*Signature of Referrer: Date / /