

# HOSPICE & SPECIALIST PALLIATIVE CARE REFERRAL FORM

Rotorua Hospice

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## 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* 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: 24 hrs 1-2 days 2-7 days  
Expected Date of Discharge from Hospital \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Reason For Referral:  
 Last Days of Life  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  No  Unknown

Copy attached  Yes  No

## 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 ? e.g. MRSA, Hepatitis

Wound/ Drain Site & Type:

Wound Care plan attached:  Yes  No

### EQUIPMENT

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

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

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

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 e.g. Drugs, Alcohol, Family Violence etc, describe please.

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

Office Use Only

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

Rotorua Community & Lake Taupo Hospices

Key Words; Hospice Referral

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