

REFERRAL FORM

Guidelines for referral to the Otago Community Hospice

Specialist palliative care services at the Otago Community Hospice are coordinated by a multidisciplinary team that works alongside and in partnership with the patient, family and community health providers. Palliative Care embraces the physical, social, emotional and spiritual elements of wellbeing and enhances a person's quality of life.

Who can be referred:

- The patient who has active, progressive disease which is no longer responsive to curative treatment and has a prognosis of less than twelve months.
- An individual identified as having difficult or complex symptoms (physical, social, emotional or spiritual). These symptoms require specialist palliative care assessment, support and management. The individual lives in Otago or is staying in Otago.

Referrals can be made for:

- Assessment of individual palliative care needs.
- Symptom management assessment, management, and advice (at person's home or inpatient admission).
- End of life care and support.

THIS REFERRAL CANNOT BE ACTIONED BY OUR TEAM WITHOUT SUFFICIENT SUPPORTING INFORMATION

What we need from you: *(either by fax or email)*

- Referral form
- Documentation confirming diagnosis
- Current medication list, including dose and frequency
- Recent correspondence from hospital specialist
- Most recent radiology reports and blood test results

PLEASE EXPECT AN ACKNOWLEDGMENT OF THIS REFERRAL

REFERRAL FORM

Patient Label OR

Name _____
Address _____
Phone No. _____
NHI No. _____
DoB _____

GP: _____

Telephone: _____

GP Aware of referral Yes No

URGENCY RATING:

- Urgent** – within 24hrs – please contact hospice directly
 Non Urgent – within five working days.

CONSENTS:

Patient Consents to Referral?

Yes No

Family Aware of Referral?

Yes No

PERSONAL REPRESENTATIVE:

Name _____

Address _____

Phone No. _____

Relationship to Patient _____

DIAGNOSIS:

Date of Diagnosis:

Relevant Medical History:
(Including Allergies)

CURRENT PROBLEMS REQUIRING SPECIALIST PALLIATIVE CARE:

Physical:

Psychosocial:

Spiritual:

SERVICES CURRENTLY INVOLVED:

Medical Specialties: Oncology Surgical Medical Older Persons Health Palliative Care Advisory
Other Services: District Nurses Cancer Society Home Help
 Community Allied Health _____ (please specify)
 Other _____ (please specify)

CHECKLIST:

- Referral Form Documentation confirming diagnosis
 Current medication list, including dose and frequency Recent correspondence from hospital specialist
 Most recent radiology reports and blood test results.

SIGNATURE: _____

Date: _____

Name of Referrer: _____

Designation: _____

Contact Telephone: _____