R E F E R R A L F O R M

Guidelines for referral to the Otago Community Hospice

Otago Community Hospice provides specialist palliative care to people with a life limiting illness. Our multidisciplinary team works in partnership with the patient, family and community health providers.

You can refer anyone living or staying in Otago with

- Active, progressive disease no longer responsive to curative treatment with a prognosis likely less than twelve months.

And

- Complex symptoms (physical, social, emotional or spiritual) resistant to standard care in the community

OUR TEAM APPRECIATE SUFFICIENT SUPPORTING INFORMATION

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

- ❑ Completed 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

IF YOU DO NOT RECEIVE ACKNOWLEDGMENT OF THIS REFERRAL PLEASE CALL US ON 03 473 6005

REFERRAL FORM

293 North Road, PO Box 8002, Dunedin
Phone: 03 473 6005
Fax: 03 473 6015
Email: clinical@otagohospice.co.nz
Web: www.otagohospice.co.nz

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.

Name of Referrer: _____ **SIGNATURE:** _____

Designation: _____ Organisation: _____

Email Address: _____ Telephone: _____ Date: _____