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

## Guidelines for referral to the Otago Community Hospice

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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

293 North Road
PO Box 8002
Dunedin
Phone: 03 473 6005
Fax: 03 473 6015
Email: carecoordinator@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

❒ Current medication list, including dose and frequency

❒ Most recent radiology reports and blood test results.

❒ Documentation confirming diagnosis

❒ Recent correspondence from hospital specialist

**SIGNATURE:** _____ Date: _____

Name of Referrer: _____ Designation: _____

Contact Telephone: _____