HOSPICE & SPECIALIST PALLIATIVE CARE REFERRAL FORM

Hospice Rotorua ○
PH:073 436 591 ext1 FAX: 07 347 8377
Post: PO Box 1092, Rotorua 3040
email:nurses@rotoruahospice.co.nz

Lake Taupo Hospice (includes Turangi) ○
PH: 07 377 4252 FAX:07 377 4253
Post: PO Box 950, Taupo 3330
email: info@laketaupohospice.co.nz

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 agrees on their behalf) ○**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 ○ 24hrs 1-2 days 2-7 days
Expected Date of Discharge from Hospital___/___/___

* Reason For Referral:
○ End Stage Care ○ Counselling ○ Symptom Management
○ Consult ○ Other

* Services Already Involved :
○ District Nurses ○ Iwi Provider ○ Cancer Society
○ O T ○ Physio ○ Home Support
○ Social Worker ○ Oncology ○ Maori Health Provider
○ Other:

DIAGNOSIS

*Primary Diagnosis:

Metastases: Lung / Liver / Brain / Bone / Lymph / Other...
*Diagnosis Date: / / Date Estimated? ○ Yes ○ No
Secondary Diagnosis:
Other Major Diagnosis:

Patient Aware of Diagnosis: Yes ○ No ○

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:

PAGE TWO MUST BE COMPLETED PLEASE, OR ASSESSMENTS ATTACHED

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 ? eg MRSA, Hepatitis

Wound/ Drain Site & Type:

Wound Care plan attached:	☐ Yes	☐ No

EQUIPMENT

OT seen & assessed ☐ Yes Who ?________________ ☐ No

Physio seen & assessed ☐ Yes Who ?________________ ☐ No

Community referrals for OT & Physio made ☐ Yes Who ?__________________ ☐ No

Equipment Required & Provider Agreed ☐ Yes ☐ No

☐ Shower stool	☐ Super stroller	☐ Lazyboy
☐ Electric Bed	☐ Other:	

Oxygen Prescribed By_________________________________ **Supplied By**____

02 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 eg Drugs, Alcohol, Family Violence etc, describe please.

Name and Designation of Referrer: ***(Please Print)*** ___________________________________

Signature of Referrer: ____________________________________**DATE**________________

Office Use Only

Entered into PalCare By:

____

Date______________________________