HOSPICE & SPECIALIST PALLIATIVE CARE REFERRAL FORM

Rotorua Hospice ○

PH: 07 343 6591 ext. 1 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: 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

○ 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:

PTO: PAGE TWO MUST BE COMPLETED PLEASE

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

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

Office Use Only

Entered into PalCare By:

_____