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:

____