Hospice Waikato Referral Form

This referral is: ☐ **Urgent (24hr response)**
☐ **Routine (72hr response)**

If this referral requires an urgent response, please telephone Hospice Waikato to discuss it further with clinical staff:
Telephone: (07) 859 1260 Fax: (07) 859 1266

Patient's Details

NHI No: | | | | | | | | |
Title: _____ DOB: / /
Surname: _____
First Name(s): _____
Preferred Name: _____
Gender: M ☐ F ☐

Address: _____
City/Town: _____ Post code: _____
Telephone: _____
Mobile phone: _____
E-mail: _____

Ethnicity: _____ First language: _____
Religion: _____
NZ Resident: Yes ☐ No ☐ (If not an NZ Resident please telephone hospice to discuss referral)

Referral Information

Primary Diagnosis: _____ Diagnosis date: / /
Other significant diagnoses/conditions: _____

Karnofsky Performance Status Score _____ Palliative Performance Scale Score _____
Patient agreed to referral: Yes ☐ No ☐ Patient aware of diagnosis / prognosis: Yes ☐ No ☐
Family agreed to referral: Yes ☐ No ☐ N/A ☐ Family aware of diagnosis / prognosis: Yes ☐ No ☐

By agreeing to this referral the patient gives Hospice Waikato permission to request further relevant health information from other health care providers as required to process this referral.

Reason(s) for referral: _____

Medical/nursing needs: _____

Social/psychological/spiritual needs: _____

Medical Team Details

GP
Name of GP: _____
Practice Name and Address: _____
Telephone: _____
Fax: _____ E-mail: _____

Specialist
Name of Specialist: _____
Hospital/DHB: _____ Dept: _____
Telephone: _____
Fax: _____ E-mail: _____

Medications

Known allergies: .....

Current medications: (please attach copy of current medication chart)

Name	Dose	Frequency

Details of Family/Carer(s)

Name	Relationship	Role NoK/EPOA/Carer	Contact (phone/address) (If different from patient)

Is there an existing Power of Attorney for Health and Welfare? Yes ☐ No ☐ (If yes please identify above)

Other Services Involved or Referred to

Organisation	Main Contact

Referrer Details

Name: ..... Position: .....

Organisation: ..... Dept: .....

Telephone: ..... Mobile: .....

E-mail: ..... Fax: .....

Further Information

Please also include relevant clinical correspondence (letters, discharge summaries, etc), test results, advance care plan

Hospice Use Only

Referral review meeting notes:

Date: Sign:

Referral decision: Accept: ☐ Decline: ☐

Urgency: Urgent ☐ Routine ☐

Team: H@H ☐ ROS ☐ IPU ☐ FS ☐ OPC ☐

Care Coordinator:

Entered in Palcare

Date:

By:

Referral source:
- ☐ General Practice
- ☐ Public Hospital – palliative care
- ☐ Public Hospital – Other
- ☐ Community Service - District Nurse
- ☐ Residential care
- ☐ Other

Diagnosis Type:
- ☐ Malignant
- ☐ Non-Malignant - Dementia
- ☐ Non-Malignant - Renal
- ☐ Non-Malignant - Other Neurological
- ☐ Non-Malignant - Cardiovascular
- ☐ Non-Malignant - Respiratory
- ☐ Non-Malignant - Multiple organ failure
- ☐ Non-Malignant - Hepatic Liver
- ☐ Non-Malignant - Other

Fax completed form to: (07) 859 1266