Rainbow Place Referral Form

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

If this referral requires an urgent response, please telephone Rainbow Place to discuss it further with clinical staff:
Telephone: (07) 859 3848 Fax: (07) 859 1266

Child/Young Person'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: _____

Child/young person agreed to referral: Yes ☐ No ☐ Child/young person aware of prognosis: Yes ☐ No ☐
Parent(s)/Guardian agreed to referral: Yes ☐ No ☐ Parent(s) /Guardian aware of prognosis: Yes ☐ No ☐

By agreeing to this referral the child/young person and/or parent/guardian gives Rainbow Place 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: _____

Immunisation status: Up to date ☐ Not known ☐

Medical Team Details

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

Lead Paediatrician
Name of Paediatrician: _____
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	Age (siblings)	Contact (phone/address) (If different from child/young person)

Is there an existing Power of Attorney for Health and Welfare? Yes ☐ No ☐

If yes provide name and contact details:

Other Services Involved or Referred to

Organisation	Main Contact

Referrer Details

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

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

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

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

Further Information / Alerts

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

Rainbow Place Use Only

Notes:

Date:

Referral decision: Accept: ☐ Decline: ☐

Urgency: Urgent ☐ Routine ☐

Key Worker:

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