



# Referral Form

334 Cobham Drive  
 PO Box 325 Waikato Mail Centre  
 Hamilton 3240  
 Ph: 07 859 1260 Fax: 07 859 1266  
 www.hospicewaikato.org.nz

**SINGLE POINT OF ENTRY TO SERVICE:-IF THIS REFERRAL NEEDS URGENT ATTENTION PHONE TO DISCUSS**  
 Hospice Waikato Standard – Routine = contact made within 24 hours of referral

**\*Triage of this referral by Hospice Waikato will be delayed if there is insufficient supporting information**

<b>PERSONAL DETAILS</b>		<p><b>* Entry criteria for admission to Hospice Waikato services for <u>adults</u>.</b>          Does the patient have <u>active progressive</u> life limiting disease with life expectancy of 12 months or less? <input type="radio"/> Yes <input type="radio"/> No          If yes to above, does the patient require specialist palliative care services? <input type="radio"/> Yes <input type="radio"/> No          Is the patient aware of diagnosis/prognosis and referral to Hospice Waikato services? <input type="radio"/> Yes <input type="radio"/> No</p>					
*NHI No:						*Title: Mr. / Mrs. / Miss / Ms / Dr	
*Family Name:			*Given Name(s):			Preferred Name:	
*Physical Address:				Postal Address(if different from physical):			
				Post Code:		Post Code:	
*Telephone:			Mobile:		Email:		
*Gender:	<input type="radio"/> Male	<input type="radio"/> Female	*Date of Birth:		*NZ Resident:	<input type="radio"/> Yes	<input type="radio"/> No
*Ethnicity:		Language Spoken:		Super Gold Card:		<input type="radio"/> Yes	<input type="radio"/> No
Country of Birth:		Interpreter Required:		<input type="radio"/> Yes	<input type="radio"/> No	High User Card:	
						<input type="radio"/> Yes	<input type="radio"/> No
<b>MEDICAL DETAILS</b>		Please attach recent copies of relevant information/letters/reports/genogram etc					
*Name of General Practitioner:							
Consultant Involved:					Specialty:		
*Currently receiving services from :		<input type="radio"/> ACC	<input type="radio"/> Acute Home Services	<input type="radio"/> DN	<input type="radio"/> DSL	<input type="radio"/> Iwi	<input type="radio"/> Other _____
<b>NEXT OF KIN/CAREGIVER DETAILS</b>							
*Full Name:				*Relationship to Patient:			
*Telephone: Day		Night/Mobile					
Address:							
<b>CURRENT MEDICATIONS:</b>				(Please attach documentation)		<b>Infectious Status</b>	
						<b>Allergies</b>	
						<b>Lives Alone</b>	
						<b>Other Alert</b>	
<b>*DIAGNOSIS AND EXTENT OF DISEASE:</b>				(Please attach copies of relevant letters & reports)			
<b>Primary Diagnosis:</b>							
<b>Secondary Diagnosis:</b>							
<b>Metastases: Lung/Liver/Brain/Bone/Lymph/Other...</b>							
<b>Other Major Diagnoses:</b>							
<b>*CURRENT PROBLEMS:</b>				Physical / Social / Psychosocial / Spiritual			
*Name of Referrer: (Please print below)				<b>Status:</b>			
				<b>Contact No:</b>			
Signature of Referrer:				<b>Date:</b>			