Referral to Hospice Waikato

Information for Referrers

CONTENTS

Introduction

Hospice Waikato accepts referrals for people who require specialist palliative care (SPC) delivered either in their own home (including Age Related Residential Care [ARRC]), at the Hospice Waikato site for Outpatient Clinics and inpatient care, or at provincial hospitals for Outpatient Clinics.

Appropriate referrals may be received from a variety of sources, including General Practitioners, specialist medical practitioners or other health professionals, community health agencies and the patient themselves (or family/whānau). Referrals are usually for people living in the Waikato Region, however, referrals from out of region or from non-New Zealand residents will be assessed on a case-by-case basis.

Referral Criteria for Adult Palliative Care Services in Midland Region

Based on the Leeds Eligibility Criteria for Specialist Palliative Care Services (Bennett, et al., 2000).

Patients must meet all five criteria below to be eligible for referral to SPC/Hospice. If there is any doubt about eligibility, the referrer should contact the service or hospice to discuss further. It will be at the discretion of the service as to whether patients who do not meet all of the criteria will be accepted.

1. ***The patient has a terminal condition that is likely to lead to their death within the next 12 months.***
   Patients eligible for **Specialist Palliative Care** are those with active, progressive, advanced disease for whom prognosis is limited and the focus of care is quality of life. An alternative term used is that of a life-limiting illness/condition. Prognostic uncertainty (such as exists when embarking on a trial of chemotherapy for an aggressive malignancy where the likelihood of response is low) should not necessarily be a barrier to referral; if there is a clinical need (criteria 2 below) the referral is likely to be accepted. Similarly, patients may be eligible for referral to Specialist Palliative Care (including Hospital Palliative Care Services) following a sudden or traumatic event in the absence of a pre-existing palliative condition (such as an intracranial haemorrhage or out of hospital cardiac arrest) if the condition is active, progressive and life-limiting.

2. ***The patient has a level of need that requires specialist palliative care.***
   The Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand (Ministry of Health Jan 2013) states that palliative care services should *"provide direct management and support of patients, their families and whānau, where more complex palliative care need **exceeds** the resources of the primary palliative care provider."* The Framework emphasises that the level of input is **needs-based** rather than just based on diagnosis or prognosis. Stated another way, referrals to SPC are appropriate where there is an **extraordinary level of need, which could include any of the following**:

   - uncontrolled or complicated symptoms;
   - specialised palliative care nursing requirements relating to mobility, functioning or self-care;
   - emotional or behavioural difficulties related to the illness, such as uncontrolled anxiety or depression;
   - concern or distress involving children, family or carers, physical and human environment (including home or hospital), finance, communication or learning disability;
   - unresolved issues around self-worth, loss of meaning and hope, suicidal behaviours, requests for euthanasia and complex decisions over the type of care, including its withholding or withdrawal.

3. ***The patient has agreed to the referral if competent to do so (or an advocate agrees on their behalf).***

4. ***The patient has New Zealand citizenship or permanent residency or belongs to one of the other categories specified in the Health and Disabilities Services Direction 2011[1], and is resident within the hospice catchment area.***

[1] Citizen of the Cook Islands, Niue or Tokelau; Australian citizen who has been or intends to be in NZ for more than 2 years; holders of a work visa (if visa expires more than 2 years after arriving in NZ); and refugees, protected persons or victims of trafficking

If the patient is not in one of the categories of eligibility and is in hospital, discuss with the hospital SPC team. If community support is needed, the referral must be discussed with the Hospice team and approval gained from the Hospice CEO prior to the referral being made to ensure funding is authorised.

The patient is registered with a local primary healthcare provider.

(Hospital inpatients without a GP must have this addressed prior to discharge if a Hospice or community palliative care referral is made).

- Patients who meet the above criteria should be referred for specialist palliative care (SPC) assessment; performed by a SPC Interdisciplinary Team. The subsequent level of involvement/intervention, treatment plan and care package will be negotiated with the patient, carer and referring team.

- If the patient is in an acute hospital with no Hospital Palliative Care Team, contact the local Hospice to assess their capacity/capability to give advice and support should that be required.

Referral Guidance

The following clinical indicators should be assessed when deciding if a referral is appropriate or not. These general indicators are based on the Gold Standards Framework Proactive Identification Guidance (Thomas, et al., 2016).

- **For patients with advanced disease or progressive life limiting conditions – ask the Surprise Question: "Would you be surprised if the patient were to die in the next year, months, weeks, days?**

The answer to this question should be an intuitive one, pulling together a range of clinical, co-morbidity, social and other factors that give a whole picture of deterioration. If you would not be surprised, then what measures might be taken to improve the patient's quality of life now and in preparation for possible further decline?

- **Do they have General Indicators of Decline?**

Refer to Step 2 in Appendix A below.

- **Do they have specific clinical indicators?**

Appendix A provides information on Specific Clinical Indicators from the Gold Standards Framework Proactive Identification Guidance. This Guidance aims to help health professionals in the earlier identification of adult patients nearing the end of their life who may need additional support (Thomas, et al., 2016).

Appendix B provides an additional tool, the Supportive and Palliative Care Indicators Tool (SPICT), which was developed as a practical, clinical tool to help multidisciplinary teams identify patients at risk of deteriorating and dying in all care settings (Highet, et al., 2014).

This information may be used to help determine if a referral is appropriate and may also be provided to Referrers to inform their decision making on who to refer and when.

Note

Most referrals to palliative care will have an expected prognosis of less than 12 months. However, not uncommonly it will either be impossible to determine prognosis with any certainty or the clinical need will be sufficient to warrant referral in the context of a life-limiting illness with a more chronic course. When in doubt, contact the Palliative Care Service or Hospice directly.

Less appropriate referrals

Specialist Palliative Care is largely inappropriate for:

- Patients with chronic stable disease or disability with a life expectancy of several years.

- Patients with chronic pain problems not associated with progressive terminal disease.

- Competent patients who decline referral.
- Patients who are unaware of their underlying disease (unless this is a cultural preference in which case this needs to be sensitively addressed).
- Those patients whose problems are principally psychological and need specialist psychiatric referral, whether or not they have declined such help.

Patients can stabilise following Specialist Palliative Care interventions and may no longer require input from that service with their ongoing care being managed by their primary palliative care provider. Discharge from the specialist palliative care service should be planned in collaboration with the primary team. Re-referral back to specialist palliative care can be made at any time should the need arise.

Referral to Hospice Waikato

Hospice Waikato operates a 'one-point entry' system for all adult patient referrals. This means that all referrals received by fax, post, electronically or other means should be managed following the process outlined in this policy.

Referrals must be on a Hospice Waikato Referral Form (Appendix C) or in the form of a referral letter that includes all relevant patient information. GPs may send an electronic referral via the Waikato DHB Regional Referral Coordination Centre, which will be forwarded to Hospice Waikato.

Referrals are accepted from General Practitioners, Specialist Medical Practitioners (hospital and private practitioners), District Nurses, Aged Related Residential Care, other hospice services, family/whānau and self-referral.

For any referral that is not from a Health Care Professional, i.e. from family/whānau or a self-referral, hospice staff are required to seek consent to consult with the patient's GP to confirm the patient meets the referral criteria and to obtain relevant clinical information.

Admission to Hospice Procedure

Once accepted into the service, the appropriate Hospice Waikato service will be notified according to the assessed needs of the patient and family/carer, and their area of residence.

- Community Nursing Service - Hamilton – Hamilton, Cambridge, Ngaruawahia
- Community Nursing Service - Rural – all other areas of Waikato Region
- Outpatient Clinic – for Hamilton, Cambridge, Ngaruawahia clinic at Hospice Waikato, for rural areas referral goes to Clinical Administrator
- Inpatient Unit – for direct transfer of a new patient requiring inpatient care (see below for IPU admission procedure)
- Family Services – for patients, family, carers requiring social, psychological and spiritual support

The patient will be contacted within 24 hours for urgent referrals, or 72 hours for non-urgent, from receipt of referral by Hospice. The care-coordinator assigned to the patient will arrange an initial visit during this first telephone contact.

The Referrer and the patient's General Practitioner will be notified of their admission to Hospice Waikato services.

A first assessment will be carried out by a Hospice Waikato nurse, doctor and/or Family Services team member. Following this assessment, a final decision will be made by the Multidisciplinary Team about the patient's appropriateness for hospice care. An Outpatient Clinic appointment or a home visit by a Hospice

Doctor may be arranged for further assessment. The Hospice nurse or doctor will communicate the assessment outcome to the GP and/or others by letter and/or telephone call, and document in the patient's PalCare record.

A Welcome to Hospice pack, including information about hospice services and contact phone numbers, will be provided to the patient and family at the first visit.

Declined Referrals

A referral may be declined by Hospice if the patient does not meet all of the referral criteria. This may be evident from information provided in the referral form and accompanying documentation. Following the first assessment and discussion by the MDT, the patient may be discharged from Hospice Waikato if no specialist palliative care needs are identified.

Hospice Inpatient Unit Admission

Patients may be admitted to the Hospice IPU for symptom/problem management, last days of life care and respite. Admissions may come from home, hospital (including wards, clinics and Emergency Department), Hospice Outpatient Clinic, or other community settings (e.g. GP practice). Generally, admissions to the IPU are for short stay periods; it is not a long-term care facility and other arrangements should be made for this type of care.

IPU admissions will be prioritised following discussion between the Palliative Medicine Senior Medical Officer (SMO) or Registered Medical Officer (RMO) with responsibility for IPU, the IPU Nursing Team Leader and the patient's General Practitioner, medical specialist or referrer where appropriate. In all instances, consultation with on duty IPU SMO/RMO will determine eligibility and admission priority.

Most admissions to the IPU will be patients already known to Hospice Waikato; however, it is possible for new patients to be referred for direct entry into the IPU. These referrals must follow the standard new patient referral process as outlined above and must also include a telephone consultation between the referrer and IPU medical and nursing staff.

If an admission is requested for a patient in Waikato Hospital (ward, clinic or Emergency Department), it is recommended that the referring team also request a consultation from the Hospital Palliative Care Consult/Liaison Service.

Criteria for IPU Admission/Prioritisation

Admissions to the IPU are possible during weekdays for patients who are already known to the hospice or where a new referral requires admission/transfer directly to IPU. Admission is dependent on bed availability and following consultation with the Senior Medical Officer responsible for IPU and the Inpatient Unit Nursing Team Leader.

The patient must be able to attend IPU before 2:30pm to allow for full medical and nursing admission procedures. Acute admission outside of this time is by negotiation with the on-call Palliative Medicine Specialist and nurse in charge of IPU. The hospice is not able to accept out of hours admissions for patients who have not already been accepted into the service.

Patients may be admitted to the IPU for the following care:

- Symptom and problem management where these are unable to be managed in the patient's current care setting. This includes all aspects of the patient's wellbeing, including physical, psychological, social and spiritual distress.

- Last days of life / terminal care where the patient cannot be cared for in their current care setting, or where the patient has requested last days of life care in the IPU (as their preferred place of death). However, last days of life care in IPU should be limited to the last few days of life.

- Respite care for patients who are stable and require predominantly nursing care only and who do not have ready access to any other respite service. Respite admissions are for a maximum of seven days and limited to two respite patients admitted at any time.

- Complex discharge planning may be considered for a patient transferred from a hospital ward with complex discharge needs.

- Day case admissions for procedures such as IV Pamidronate infusion and paracentesis.

Priority for IPU admissions

In all cases, community patients known to hospice will have priority admission into the IPU. The following is a guide to IPU admission priorities:

1. Community patients with acute symptom/problem management (including admission for family/carer social crisis)

2. Community patients in the last days of life when not able or not wishing to die at home

3. Transfer from hospital Emergency Department

4. Transfer from hospital ward or Outpatient Clinic

5. Booked respite care

Processes for Admission to the Inpatient Unit

There are several different ways in which a patient may be referred for admission to the IPU, including referrals from different health professionals and for the different types of admission. In all cases, the Palliative Medicine SMO with responsibility for the IPU will make the final decision on admissions.

Any patient needing admission or transfer (e.g. from home, Waikato Hospital ED/wards/clinics) must be discussed with the Palliative Medicine SMO or RMO responsible for IPU or Palliative Medicine SMO on-call, and the IPU Nursing Team Leader / Nurse in Charge before admission to the Inpatient Unit is accepted.

Definitions

Source: New Zealand Palliative Care Glossary (The Palliative Care Council of New Zealand, Hospice New Zealand & the Ministry of Health, (2012)[2] and Children, Young Persons, and Their Families Act 1989[3]

Last days of life

The last days of life phase begins when a judgement is made that death is imminent. It may be the judgement of the health/social care professional or team responsible for the care of the patient, but it is often the patient or family who first recognises its beginning.

Life-limiting condition

A life-limiting condition is one for which there is no reasonable hope of cure and from which the person will die. Some of these conditions cause progressive deterioration rendering the person increasingly dependent on family and carers.

Life-threatening condition

Life-threatening conditions are those for which curative treatment may be feasible but can fail. A life-threatening condition is usually of short duration with an acute or unexpected onset and may or may not occur in the context of a pre-existing life-limiting condition.

Palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization, 2002). Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Specialist palliative care

Specialist palliative care is palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals. Specialist palliative care may be provided by hospice or hospital based palliative care services where patients have access to at least medical and nursing palliative care specialists.

Terminal condition

A progressive condition that has no cure and that can be reasonably expected to cause the death of a person within a foreseeable future. The definition is inclusive of both malignant and non-malignant conditions and ageing.

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[2] The Palliative Care Council of New Zealand, Hospice New Zealand & the Ministry of Health. (2012). *New Zealand Palliative Care Glossary*. Available from: http://www.cancercontrolnz.govt.nz/pub/new-zealand-palliative-care-glossary.

[3] Children, Young Persons, and Their Families Act 1989

Appendix A: GSF Proactive Identification Guidance (PIG)

K. Thomas, J. Armstrong Wilson and GSF Team (2016) GSF PIG 6th Edition. National Gold Standards Framework Centre in End of Life Care (http://www.goldstandardsframework.org.uk).

Step 1: The Surprise Question

For patients with advanced disease or progressive life limiting conditions, would you be surprised if the patient were to die in the next year, months, weeks, days?

The answer to this question should be an intuitive one, pulling together a range of clinical, co-morbidity, social and other factors that give a whole picture of deterioration. If you would not be surprised, then what measures might be taken to improve the patient's quality of life now and in preparation for possible further decline?

Step 2: General Indicators of decline and increasing needs?

- General physical decline, increasing dependence and need for support.
- Repeated unplanned hospital admissions.
- Advanced disease – unstable, deteriorating, complex symptom burden.
- Presence of significant multi-morbidities.
- Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day and increasing dependence in most activities of daily living.
- Decreasing response to treatments, decreasing reversibility.
- Patient choice for no further active treatment and focus on quality of life.
- Progressive weight loss (>10%) in past six months.
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home.
- Serum albumin <25g/l.

Step 3: Specific Clinical Indicators

A. Cancer - rapid or predictable decline

- Deteriorating performance status and functional ability due to metastatic cancer, multi-morbidities or not amenable to treatment – if spending more than 50% of time in bed/lying down, prognosis estimated in months.
- Persistent symptoms despite optimal palliative oncology.

More specific prognostic predictors for cancer are available, e.g. PPS.

B. Organ Failure

Heart Disease

At least two of the indicators below:

- Patient for whom the surprise question is applicable.
- CHF NYHA Stage 3 or 4 with ongoing symptoms despite optimal HF therapy – shortness of breath at rest on minimal exertion.
- Repeated admissions with heart failure – 3 admissions in 6 months or a single admission aged over 75 (50% 1yr mortality).
- Difficult ongoing physical or psychological symptoms despite optimal tolerated therapy.
- Additional features include hyponatraemia <135mmol/l, high BP, declining renal function, anaemia, etc.

Chronic Obstructive Pulmonary Disease (COPD)

At least two of the indicators below:

- Recurrent hospital admissions (at least 3 in last year due to COPD)
- MRC grade 4/5 – shortness of breath after 100 metres on level
- Disease assessed to be very severe (e.g. FEV1 <30% predicted), persistent symptoms despite optimal therapy, too unwell for surgery or pulm rehab.
- Fulfils long term oxygen therapy criteria (PaO2<7.3kPa).
- Required ITU/NIV during hospital admission.

Other factors e.g., right heart failure, anorexia, cachexia, >6 weeks steroids in preceding 6 months, requires palliative medication for breathlessness still smoking.

Kidney Disease

Stage 4 or 5 Chronic Kidney Disease (CKD) whose condition is deteriorating with at least two of the indicators below:

- Patient for whom the surprise question is applicable.
- Repeated unplanned admissions (more than 3/year).
- Patients with poor tolerance of dialysis with change of modality.
- Patients choosing the 'no dialysis' option (conservative), dialysis withdrawal or not opting for dialysis if transplant has failed.
- Difficult physical or psychological symptoms that have not responded to specific treatments.
- Symptomatic Renal Failure in patients who have chosen not to dialyse – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload.

Liver Disease

Hepatocellular carcinoma.

Liver transplant contra indicated.

Advanced cirrhosis with complications including:

- Refractory ascites
- Encephalopathy
- Other adverse factors including malnutrition, severe comorbidities, Hepatorenal syndrome
- Bacterial infection current bleeds, raised INR, hyponatraemia, unless they are a candidate for liver transplantation or amenable to treatment of underlying condition.

General Neurological Diseases

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Symptoms which are complex and too difficult to control.
- Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure.
- Speech problems: increasing difficulty in communications and progressive dysphasia.

Parkinson's Disease

- Drug treatment less effective or increasingly complex regime of drug treatments.
- Reduced independence, needs ADL help.
- The condition is less well controlled with increasing "off" periods.
- Dyskinesias, mobility problems and falls.
- Psychiatric signs (depression, anxiety, hallucinations, psychosis).
- Similar pattern to frailty – see below.

Motor Neurone Disease

- Marked rapid decline in physical status.
- First episode of aspirational pneumonia.
- Increased cognitive difficulties.
- Weight Loss.
- Significant complex symptoms and medical complications.
- Low vital capacity (below 70% predicted spirometry), or initiation of NIV.
- Mobility problems and falls.
- Communication difficulties.

Multiple Sclerosis

- Significant complex symptoms and medical complications.
- Dysphagia + poor nutritional status.
- Communication difficulties e.g., Dysarthria + fatigue.
- Cognitive impairment notably the onset of dementia.

C. Frailty / Dementia / CVA - gradual decline

Any person who fits within this category of diseases should already have had a referral to, and assessment by, a District Health Board funded Needs Assessment Service. This will ensure that both the patient and their family/carers have access to DHB funded supportive care programmes and funding appropriate to the patient's disease and identified needs. Specialist Palliative Care Services are not equipped to provide all of the service components necessary to care for those with frailty, dementia or the consequences of a severe cerebral vascular accident.

Frailty

For older people with complexity and multiple comorbidities, the surprise question must triangulate with a tier of indicators, e.g. through Comprehensive Geriatric Assessment (CGA).

- Multiple morbidities.
- Deteriorating performance score.
- Weakness, weight loss exhaustion.
- Slow Walking Speed – takes more than 5 seconds to walk 4 m.
- TUGT – time to stand up from chair, walk 3 m, turn and walk back.
- PRISMA – at least 3 of the following: Aged over 85, Male, Any health problems that limit activity?, Do you need someone to help you on a regular basis?, Do you have health problems that cause require you to stay at home?, In case of need can you count on someone close to you?, Do you regularly use a stick, walker or wheelchair to get about?

Dementia

Identification of moderate/severe stage dementia using a validated staging tool e.g., Functional Assessment Staging has utility in identifying the final year of life in dementia. (BGS) Triggers to consider that indicate that someone is entering a later stage are:

- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- No consistently meaningful conversation and
- Unable to do Activities of Daily Living (ADL)
- Barthel score >3

Plus any of the following: Weight loss, Urinary tract Infection, Severe pressure injuries – stage three or four, Recurrent fever, Reduced oral intake, Aspiration pneumonia.

NB Advance Care Planning discussions should be started early at diagnosis.

It is vital that discussions with individuals living with dementia are started at an early to ensure that whilst

they have mental capacity, they can discuss how they would like the later stages managed.

Stroke (Cerebral Vascular Accident)

- Use of validated scale such as NIHSS recommended.
- Persistent vegetative, minimal conscious state or dense paralysis.
- Medical complications, or lack of improvement within 3 months of onset.
- Cognitive impairment / Post-stroke dementia.
- Other factors e.g. old age, male, heart disease, stroke sub-type, hyperglycaemia, dementia, renal failure.

Appendix B: Supportive and Palliative Care Indicators Tool (SPICT)

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Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates

SPICT™, April 2017

Appendix C: Referral Form

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 ☐

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