

THIS REFERRAL CANNOT BE ACTIONED BY OUR TEAM IF -

1. The patient does not consent to referral.
2. There is insufficient supporting information e.g., clinical notes.

ALL QUESTIONS IN *BOLD* MUST BE COMPLETED. Please include adequate information to enable us to complete this process accurately.

Patient consent: Yes ☐ No ☐ Next of kin aware of referral: Yes ☐ No ☐ Patient aware of Diagnosis: Yes ☐ No ☐

Referral priority: Urgent (<24hrs) ☐ Semi-urgent (1-3 Days) ☐ Routine (4-7days) ☐

If urgent, you MUST call the Hospice Waikato team on (07) 859 1260

Urgent referrals: Patient unstable (uncontrolled symptoms)

Semi-urgent referrals: Patient is experiencing distressing physical and/or psychosocial symptoms and not responding to established palliative care management/protocols.

Routine referrals: Patient is stable but seeking palliative care information and support.

Date of referral:/...../.....

Time Sent:

Current location of patient: Aged residential care facility ☐ Hospital ☐ Private residence ☐

NHI:	First name:	Surname:	Gender:
DOB:	Ethnicity:	Language Spoken:	Country of Birth
Address:			Marital Status:
Phone:		Email Address:	
Name of GP:		Name of Specialist:	
Name of GP Practice:		Speciality:	
Primary diagnosis:		Secondary diagnosis/comorbidities:	

Does this patient meet ALL of the general referral criteria (see over page for criteria)? Yes ☐ No ☐

Date of diagnosis:	AKPS/performance status:	Allergies:
Estimated prognosis: Hours ☐ Days ☐ Weeks ☐ Months ☐ A year or more ☐		
Medication (please specify any changes)	Dose	Frequency

Social situation (e.g., lives alone):	
Main Caregiver Name: Address: Phone:	Relationship to patient:

What are the specific issues for which you would like specialist palliative care input?

☐ Complex pain/symptom management ☐ Complex psychosocial/allied health support needs ☐ End-of-life care ☐ Other	Comments (symptoms, main concerns, current and proposed treatment):
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IMPORTANT:

Please attach any latest correspondence to support the referral including hospital discharge summary if patient is being discharged from hospital.

Referrer Details:

Name:

Position:

Organisation:

Contact Phone:

Email:

For Hospice to complete:

Date & Time Referral Received: Date:/...../..... Time:

Please send all referrals to: clinical.admin@hospicewaikato.org.nz

Alternatively, you can fax this referral form to: (07) 859 1266

REFERRAL CRITERIA FOR ACCEPTANCE BY HOSPICE WAIKATO (referrals must meet ALL of the criteria below)

- The patient is resident in the Waikato Region.
- The patient is registered with a local GP (will work with patient around this if required).
- The patient has documented active, progressive and advanced disease.
- The patient has an extraordinary level of need (physical, psychological, spiritual) that exceeds the resources of the primary palliative care provider and specialist input is required.

AKPS (Australian-modified Karnofsky Performance Score)

AKPS	Features:
100	Normal with no evidence of disease
90	Able to carry out normal activity with only minor symptoms of disease
80	With some effort able to carry out normal activity with some symptoms of disease
70	Care for self but unable to carry on normal activity or to do active work
60	Mostly able to care for self but requires occasional assistance
50	Considerable assistance and frequent medical care required
40	In bed more than 50% of the time
30	Almost completely bedbound
20	Totally bedbound and requiring extensive nursing care by professionals
10	Comatose or barely rousable