# 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: ____________________ Address: ____________________
Title: ____________________ DOB: ____/____/____
Surname: ____________________ City/Town: ____________________ Post code: __________
First Name(s): ____________________ Telephone: ____________________
Preferred Name: ____________________ Mobile phone: ____________________
Gender: M ☐ F ☐ 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 |
|---|---|---|
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## 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**