Waipuna Hospice
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REFERRAL FOR SERVICES

Date:	☐ **Urgent** *(1-2 Working Days)* ☐ **Routine** *(2-4 Working Days)*			
Patient consent to referral: Yes / No *(Please note, consent is required prior to referral)*				
Family Name	**Given Name**	**NHI Number**		
Address		Phone Number/s Home: Cell:		
Ethnicity	Age	Date of Birth	Gender	GP: Practice:
NZ Citizen / Resident: ☐ Yes ☐ No		Preferred language:		
NOK	NOK Contact details			

What are this patient's specialist palliative care needs?

Details:

	None	Potential	Significant
Physical symptoms			
Social needs			
Psychological/ Emotional			
Cultural/ Spiritual			

Primary disease process	**Co-morbidities**	
Social situation ☐ Lives alone ☐ Lives with others, no support provided ☐ Lives with others who provide support ☐ Receives external supports ☐ Other:_____	**Mobility** ☐ Ambulant independently ☐ Ambulant with aids ☐ Bedbound Details: _____	**Known Allergies or Alerts** *(including infectious status/ ICD / pacemaker/community safety risks)*

Other services involved:

☐ Medical Oncology	☐ OT/ Physio	☐ Support Net
☐ Radiation Oncology	☐ Social Work	☐ Short Term Services
☐ Cancer Society	☐ Iwi provider	☐ Speech Language Therapy
☐ Cardiac	☐ District Nursing	☐ ACC
☐ Respiratory	☐ Mental Health Services	☐ Other: _____

PLEASE ATTACH REQUIRED DOCUMENTATION- *referrals cannot be processed without this information*

MEDICATION LIST ☐ **HOSPITAL DISCHARGE SUMMARY** ☐ **RECENT CLINIC LETTERS/ GP NOTES** ☐

Referred by:	**Organisation:**	**Signature:**
Designation:		
Referrer fax:	**Phone:**	