Prefer to use the online referral form?
http://midland.palcare.co.nz/referral/
(no login or password required)

Hospice EBOP
39 Goulstone Rd, PO Box 275
Whakatane 3158
Ph 07 307 2244
Fax 07 307 8057

COMMUNITY HOSPICE PALLIATIVE CARE SERVICES REFERRAL FORM

PATIENT INFO	**REFERRAL INFO**
NHI	Referral date
Last Name First Names Preferred Name	Reason for referral *(tick)* □ Symptom Management □ Counseling □ Respite Care □ End Stage Care □ Other (*Specify*) ……
DOB Age Gender □ Male □ Female	Patient consented to referral? □ Yes □ No ***Please note that consent is required prior to referral being completed.***
Referral Priority: Urgent □24 hrs Semi Urgent □1-2 days Non Urgent (within a week) □2-7 days	
Are you aware of any risks to be taken into account for safe delivery of care in the community? (e.g., drug use, aggression etc.) Please provide details below or phone HEBOP Clinical Services Leader to discuss.	
Marital status	Has Primary Carer? □ Yes □ No □ Unknown
Address	Next of Kin Name
Town Post Code	Next of Kin Relationship
Phone Mobile	Next of Kin Phone
GP Name GP Practice Specialist Name Specialist Hospital/Clinic	Services Involved □ District Nurses □ Iwi Provider □ Cancer Society □ Home Support □ Physio □ Oncology □ Social Worker □ OT □ Maori Health □ Other .....
Language spoken	Primary Diagnosis Type □ Malignant □ Non Malignant
Interpreter required? □Yes □ No Ethnicity	Diagnosis
Iwi	Diagnosis Date *(use ± if estimated)*
Is this patient a NZ Citizen/Resident? □Yes □ No	Patient Aware of diagnosis? □Yes □ No

Identified Needs Psychosocial Patient / Whanau	**Identified Needs Medical/Nursing**	**Alerts**
		Allergies? Infectious Status? Pacemaker/ ICD? Other Alert?

Referrer Name & Position

Agency **Phone number**

Fax form to Hospice EBOP on 07 307 8057 with recent scans, blood results and reports