BARCODE AREA

MIDCENTRAL HEALTH

AROHANUI HOSPICE

REFERRAL TO MDHB SPECIALIST PALLIATIVE CARE SERVICES

PLEASE COMPLETE THIS REFERRAL FORM AS FULLY AS POSSIBLE.

Please note: Arohanui Hospice staff have limited access to Palmerston North Hospital information.

Service Requested		Urgency for either service
☐	**Community: Arohanui Hospice** (community, including aged residential care and other facilities) **FAX: (06) 356 6631** **Telephone: (06) 356 6606**	☐ Within 24 hours ☐ 24–72 hours ☐ Non-urgent
☐	**Hospital: Palmerston North Hospital Palliative Care Service** (inpatients) **FAX: 8431** **Telephone: 7484** and/or page a team member **After hours** contact Arohanui Hospice	

REASON FOR REFERRAL (please √): Referral may be appropriate if the patient has active, progressive, advanced disease and the level of palliative care need exceeds that which the current provider can offer.

☐	Uncontrolled or complicated symptoms	☐	Last days of life support: patient, family, staff/facility
☐	Emotional, psychosocial or existential issues related to the illness	☐	Other:

Patient aware of diagnosis?	Yes / No	**Patient/advocate consents to referral?**	Yes / No
Patient aware of prognosis?	Yes / No	**Family/NOK aware of referral?**	Yes / No

BINDING MARGIN – NO WRITING

PATIENT DETAILS/PATIENT LABEL: DOB ..... Patient NHI .....

Surname ..... First names .....

Address .....

.....

Email ..... Ethnicity .....

Current location of patient ..... Contact phone no .....

Usual accommodation: (select one)

☐ Private residence (incl. retirement village)
☐ Residential aged care, low level care (level 2 rest home)
☐ Residential aged care, high level care (hospital level)
☐ Other (eg corrections facility) .....
.....
.....

Level of current support: (select one)

☐ Lives with others with no care/support provided
☐ Lives alone with no care/support provided
☐ Lives alone with external professional support
☐ Lives with others who provide care/support
☐ Lives with others with external professional support
☐ Not stated/inadequately described/not applicable

NEXT OF KIN/CONTACT PERSON'S DETAILS:

Surname ..... First Names .....

Address .....

..... Email .....

Phone no ..... Relationship .....

HEALTH PROFESSIONAL DETAILS (Complete if the General Practitioner is not the referrer)

GP ..... Phone no .....

Address .....

Consultant(s) .....

PLEASE TURN OVER

PATIENT NAME: **NHI:**

DISEASE STATUS:

Diagnosis ..... **Date of Diagnosis** .....

Site of Metastases (if malignancy) .....

Past/current management of this diagnosis: *(including date of any major surgery in past year)*

Relevant Past Medical History: *(attach a copy of the patient summary if preferred)*

Current Medications *(copy of drug chart is preferred)*

Allergies/adverse drug reactions:

Current issues requiring specialist palliative care support:

Uncontrolled physical symptoms:

Psychosocial issues:

Family social circumstances:

Additional relevant information: *(eg barriers to communication – language, hearing)*

For community patients: Please supply most recent hospital OPD letters/discharge summary

☐ Attached ☐ Not available

.....

.....

Date of last medical consultation: ..... /..... /.....

COMMUNITY PATIENTS	HOSPITAL INPATIENTS
Name of referring Dr or NP:	**Name of referring Dr or NP:**
GP Practice:	**If the referrer is not the consultant, please ensure the consultant has given consent (signature implies this has been done).*
Contact phone number:	Name of consultant:
Hospital Clinic/Speciality:	Pager number:
Signature: Date:	Signature: Date:

BINDING MARGIN – NO WRITING