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

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

# COMMUNITY HOSPICE PALLIATIVE CARE SERVICES REFERRAL FORM

| **PATIENT INFO** | **REFERRAL INFO** |
|---|---|
| NHI | Referral date |
| Last Name<br>First Names<br>Preferred Name | Reason for referral *(tick)*<br>□ Symptom Management □ Counseling<br>□ Respite Care □ End Stage Care<br>□ Other (*Specify*) …… |
| DOB Age<br>Gender □ Male □ Female | Patient consented to referral? □ Yes □ No<br>***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<br>GP Practice<br>Specialist Name<br>Specialist Hospital/Clinic | Services Involved □ District Nurses □ Iwi Provider<br>□ Cancer Society □ Home Support □ Physio<br>□ Oncology □ Social Worker □ OT<br>□ Maori Health □ Other ..... |
| Language spoken | Primary Diagnosis Type □ Malignant □ Non Malignant |
| Interpreter required? □Yes □ No<br>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?<br>Infectious Status?<br>Pacemaker/ ICD?<br>Other Alert? |

**Referrer Name & Position**

**Agency** **Phone number**

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