Palliative Care Patient Referral Form

Referred to: Drakenstein Palliative Hospice **Attention:** .....

E-mail: admin@drakensteinhospice.org.za **Fax No:** 086 611 5473 **Tel No:** 021 872 4060 **Emergency:** 082 200 4221

PERSONAL INFORMATION

Patient's Name: **M / F**	Hospital Folder No:
Date of Birth:	**Medical Aid:** Plan:
ID No:	Main Member: ID No:
Postal Address:	Medical Aid Number: ICD Code:
Street Address:	Person resp. for account:
Directions:	Contact No: e-mail:
Tel No:	**Next of Kin:**
Cell No:	Tel No: e-mail:
E-mail:	Relationship:

MEDICAL INFORMATION

Diagnosis:					**Past** Medical History:
			Date:		
Secondary Diagnosis:					
Metastasis:	Lung	Brain	Liver	Nodes	**Current** Symptoms:
Bone:					
Other:					

a) Surgery	YES	NO	Curative	Palliative	Description:
b) Radiotherapy	YES	NO	Curative	Palliative	Site:
c) Chemotherapy	YES	NO	Curative	Palliative	Regime:
d) Further Treatment	YES	NO	Curative	Palliative	Plan:

TB	YES	NO	Previous	Type:	Rx Date:
RVD	YES	NO	WHO Stage:	CD4: Date:	1st CD4: Date:

Patient Karnovsky Scale:

1. Ambulant	**2.** <50% Bed Bound	**3.** >50% Bed Bound	**4.** Bed Bound

CURRENT MEDICATION

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Drug idiosyncrasies / allergies:

SYMPTOM MANAGEMENT REQUIRED

Pain/Symptom Management		Emotional Support		Orphans / Vulnerable Children	
Incontinence / Constipation		Social Support / Groups		Stoma Care / Support	
Neurological Needs		Spiritual Support / Counselling		ARV / TB / Meds Management	
Pressure / Wound Care		Grant Application		Information / Training needed	
Other:					

MEDICAL CONTACTS

Referring Specialist	Referring GP	Referring SW/ Nurse/family
Address:	Address:	Address:
E-mail:	E-mail:	E-mail:
Tel No:	Tel No:	Tel No:

PSYCHOSOCIAL ASPECTS

- What has the patient and immediate family been **told** about his / her illness? ……..

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- Are there any **other home care agencies** involved in the patient's care? Who are they?

……..……..

- Does Hospice have **permission** to provide holistic homecare? YES | NO

Pt/family giving permission	Signature	Date	Person obtaining permission	Signature	Date

- Is there a **special reason** for this referral / extra information? ……..

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Completed by: ……. Signature: ……Title: ……

Tel No: ……. E-mail:……..……..… Date: ……..……