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| **REFERRAL FOR:**(a ‘Direct Electronic Referral’ is available on our website <https://hospicesc.org.nz/>or use direct ERMS referrals) | [ ]  In-patient  |
| [ ]  Therapeutic Day at ‘The Cottage’ |
| [ ]  Biography service |
| [ ]  ‘Relax & Revive’ Complementary Therapy service |
| [ ]  Grief & Loss counselling |
| [ ]  Hospice in the home Night Carer service | (please use ‘Hospice in the Home Night Carer service Referral Form’ which includes the home risk assessment) |
| [ ]  Out Patient Clinic (with Palliative Specialist Doctor) |
| [ ]  ‘Better Breathing’ course |
| [ ]  ‘Carer Skills’ course |
| **PERSON REFERRED:** | [ ] Palliative patient [ ] Family / carer [ ] Patient *(not Palliative)* |
| Name:      | Doctor: [ ]  N/A       |
| Preferred Name:      | NHI: [ ]  N/A      |
| Diagnosis: [ ]  N/A      |
| Address:      | Date of birth:      |
| Phone / Cell number:      | Email:      |
| Person is aware of referral [ ]  |
| Other issues to be aware of and summarised e.g. [ ]  *(other documents/history attached)* |
| Symptom ManagementEnd-of-life careEthnicityNZ Resident [ ] Language issuesInterpreter Required [ ] Marital StatusLiving SituationOccupationFamily RelationshipsChildren (Ages) |       |
| CONTACT person (Whānau/next-of-kin, spokesperson): *(a contact person MUST be provided for clinic patients)* |
| NameAddressPhone number/sEmailRelationship to referred person |       |
| REFERRER: | SERVICE: | DATE: |
|       |       |       |
| EMAIL TO: Hospice South Canterbury In-patient unit or Administration nurses@hospicesc.org.nz support@hospicesc.org.nz  |

*(for IN-PATIENT referrals Hospice Nurse to complete details over page)*

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| **FOR HOSPICE IN-PATIENT USE:** |
| **Before admission is accepted:** | General (or Nurse) Practitioner is consulted & is aware of referral ? | Y / N | By either the: | Hospital Medical team |  |
| Community / specialist nurse |  |
| If not - by the hospice nurse: |  |
| General (or Nurse) Practitioner is able to visit within 24 hours? | *(details)* |
| **ACCEPTED:** |  | **ADMISSION DATE:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Symptom Management |  | End Of Life Care |  | Respite |  | Other |  |

|  |  |
| --- | --- |
| Other relevant details: |  |
| Medications if known: |  |
| Plan: |  |

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| REQUESTED INFORMATION: |
| Medication List: |  | Doctor’s Letter/History: |  | Medical History: |  | Palliative Team notes: |  |
| Nursing Transfer Form: |  | Syringe Driver: |  | Oxygen: |  |  |  |
| NAME OF PERSON COMPLETING FORM: | SIGNATURE: | DESIGNATION: | DATE: |
|  |  |  |  |

*‘Form’ filed in & patient name listed in Green Folder*