|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Management  End-of-life care  Ethnicity  NZ Resident  Language issues  Interpreter Required  Marital Status  Living Situation  Occupation  Family Relationships  Children (Ages) | | |  | | | | |
| CONTACT person (Whānau/next-of-kin, spokesperson): *(a contact person MUST be provided for clinic patients)* | | | | | | | |
| Name  Address  Phone number/s  Email  Relationship to referred person | | |  | | | | |
| REFERRER: | | | | SERVICE: | | | DATE: |
|  | | | |  | | |  |
| EMAIL TO: Hospice South Canterbury In-patient unit or Administration  [nurses@hospicesc.org.nz](mailto:nurses@hospicesc.org.nz) [support@hospicesc.org.nz](mailto:support@hospicesc.org.nz) | | | | | | | |

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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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*