



PATIENT REFERRAL FORM

PLEASE NOTE THAT ONLY IN EXCEPTIONAL CIRCUMSTANCES SHOULD PATIENTS BE REFERRED WHO ARE AWARE OF THEIR DIAGNOSIS

Coast Hospice Ref no. _____

Patient's Name _____ Age: _____ Sex: Female Male

Address: _____

Telephone No. _____

Consultants (s) in charge of patients: _____

Diagnosis: _____

Primary Site: _____

Secondary Deposits: _____

Date of Diagnosis: _____

How was diagnosis confirmed? _____

(Please attach a copy of Histology Report)

Reason for Referral: _____

What has the patient been told about the Diagnosis? _____

What is the expected prognosis? _____

Has the patient been informed of the referral? **YES/NO**

If not please discuss with a member of the Hospice Team before referral.

HOSPITAL PATIENTS ONLY:

Hospital: _____ Ward: _____ File No. _____

Date of Admission _____ Date of Discharge _____

"Bringing Peace into their days"

Please Turn Over

Current Treatment: _____

Previous Treatment: _____

Surgery: (with details and dates) _____

Radiotherapy: (with details and date) _____

Chemotherapy: (with details and date) _____

Hormone therapy: (with details and date) _____

Past medical history: _____

Where can the patient be seen? _____

In hospital At home At the Hospice

Does referring doctor wish to

- | | | | | |
|--|--------------------------|------------|--------------------------|-----------|
| 1. Share care with the Hospice doctor? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 2. Consultation only with Hospice doctor? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 3. Have Hospice palliative care team take over care? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

Patient/Relative's Signature _____

Referring doctor (Please Print)

Name: _____

Address: _____

Telephone No. _____

Signature: _____ Date: _____

"Bringing Peace into their days"