Hospice Tairawhiti
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REFERRAL FOR SERVICES

Living Every Moment hospice Tairawhiti

Date:	☐ **Urgent** *(Within 24hrs)* ☐ **Routine** *(2-7 Working Days)* ☐ **Inpatient Consult only**

Patient consent to referral: Yes / No *(Please note, consent is required prior to referral)*

Family Name	**Given Name**	**NHI Number**

Address	Phone Number/s Home: Cell:

Ethnicity	Age	Date of Birth	Gender	GP: Practice:

NOK & Relationship	NOK Contact details

What are this patient's specialist palliative care needs?

Details / Current Situation:

	None	**Potential**	**Significant**
Physical symptoms			
Social needs			
Psychological/ Emotional			
Cultural/ Spiritual			

Primary disease history	**Co-morbidities**

Social situation	**Mobility**	**Known Allergies or Alerts**
	☐ Ambulant independently ☐ Ambulant with aids ☐ Bedbound Details: _____	*(including infectious status/ ICD / pacemaker/community safety risks)*

Other services involved:

☐ Medical Oncology	☐ OT/ Physio	☐ NASC
☐ Radiation Oncology	☐ Social Work	☐ Speech Language Therapy
☐ Cancer Society	☐ Iwi provider	☐ ACC
☐ Cardiac	☐ District Nursing	
☐ Respiratory	☐ Mental Health Services	☐ Other: _____

Please attach documentation where availible- *Clinic letters/ GP notes/ hospital discharge summaries/ medications/ recent scans/ blood results*

Referred by:	**Organisation:**
Signature:	**Phone:**
Designation:	**Referrer fax:**