HOSPICE SOUTH CANTERBURY
REFERRAL FORM

REFERRAL FOR:	☐	In-patient	
	☐	Therapeutic Day at 'The Cottage'	
	☐	Biography service	
	☐	'Relax & Revive' Complementary Therapy service	
	☐	Grief & Loss counselling	*(please use 'Grief & Loss Support Referral Form')*
	☐	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 Y / N Language issues Interpreter Required Y / N Marital Status Living Situation Occupation Family Relationships Children (Ages)	

CONTACT person (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:**

FAX TO: Hospice South Canterbury In-patient unit 03 6877676 or Administration 03 6877671
OR EMAIL: nurses@hospicesc.org.nz or 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