Waipuna HOSPICE
Life is Special

REFERRAL FOR SERVICES

Waipuna Hospice
Ph: 07 552 4380
Fax: 07 552 4386
Email: referrals@waipuna-hospice.co.nz
www.waipuna-hospice.co.nz

Date: ☐ **Urgent** *(1-2 Working Days)* ☐ **Routine** *(2-4 Working Days)*

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:

NZ Citizen / Resident: ☐ Yes ☐ No

Preferred language:

NOK | NOK Contact details

What are this patient's specialist palliative care needs?

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

Details:

Primary disease process

Co-morbidities

Social situation

- ☐ Lives alone
- ☐ Lives with others, no support provided
- ☐ Lives with others who provide support
- ☐ Receives external supports
- ☐ Other:____________________

Mobility

- ☐ Ambulant independently
- ☐ Ambulant with aids
- ☐ Bedbound
  Details: ______________

Known Allergies or Alerts
(including infectious status/ ICD / pacemaker/community safety risks)

Other services involved:

- ☐ Medical Oncology
- ☐ Radiation Oncology
- ☐ Cancer Society
- ☐ Cardiac
- ☐ Respiratory
- ☐ OT/ Physio
- ☐ Social Work
- ☐ Iwi provider
- ☐ District Nursing
- ☐ Mental Health Services
- ☐ Support Net
- ☐ Short Term Services
- ☐ Speech Language Therapy
- ☐ ACC
- ☐ Other: ____________________

PLEASE ATTACH REQUIRED DOCUMENTATION- *referrals cannot be processed without this information*

MEDICATION LIST ☐ **HOSPITAL DISCHARGE SUMMARY** ☐ **RECENT CLINIC LETTERS/ GP NOTES** ☐

Referred by:

Organisation:

Signature:

Designation:

Referrer fax:

Phone: