



# REFERRAL FORM

*Please use this form to refer patients who require specialist palliative care services*

**Please Fax To:**  
(06) 356 6631

**Urgency**

- Within 24 hours
- 24-72 hours
- Non urgent

Member of Palliative Care Partnership

**Patient Details:**

Surname: ..... First Names: .....

Address: .....  
.....

DOB: ..... Ethnicity: ..... Patient NHI: .....

Current Location of Patient: ..... Home phone number: .....

**Next of Kin Details:**

Surname: ..... First Names: .....

Address: .....  
.....

Telephone No: ..... Relationship: .....

**Professional Details:**

GP: ..... Address: ..... Tel No: .....

Consultant(s): .....

**Disease Status:**

Diagnosis: ..... Date of Diagnosis .....

Site of Metastases (if malignant) .....

Past / current management of this diagnosis: (including date of any major surgery in past year)

**Reason for Referral:**

- Uncontrolled complex symptoms .....
- Psychosocial issues .....
- Patient is considered to have less than 12 months to live
- End of life support
- Other.....

**PLEASE TURN OVER**



**Relevant Past Medical History:**

**Current Medication:**

**Allergies / adverse drug reactions:**

**Current problems:**  
 Uncontrolled physical symptoms:

Psychosocial issues:

Family social circumstances:

Additional relevant information:

<b>Patient aware of diagnosis?</b>	<b>Yes / No</b>	<b>Patient aware of referral?</b>	<b>Yes / No</b>
<b>Patient aware of prognosis?</b>	<b>Yes / No</b>	<b>Family / NOK aware of referral?</b>	<b>Yes / No</b>

**Please supply further documentation to support referral**  
 eg. lab results/hospital letter/discharge summary .....

**Date patient last seen by Medical Practitioner:** .....

**Referring Person:**

Name: .....

Signature: .....

Location: .....

Date: .....

Contact phone number: .....