Te Whatu Ora
Health New Zealand
Te Pae Hauora o Ruahine o Tararua
MidCentral

Referral to MidCentral Specialist Palliative Care Services

Arohanui HOSPICE

PLEASE COMPLETE THIS REFERRAL FORM AS FULLY AS POSSIBLE

Please note: Arohanui Hospice staff have limited access to Palmerston North Hospital information.

Service Requested		Urgency for Either Service
☐	**Community: Arohanui Hospice** (community, including aged residential care and other facilities) **EMAIL: referrals@arohanuihospice.org.nz** **Phone: (06) 356 6606**	☐ Within 24 hours ☐ 24–72 hours ☐ Non-urgent
☐	**Hospital: Palmerston North Hospital Palliative Care Service** (inpatients) **EMAIL: HPCT@midcentraldhb.govt.nz** **Phone ext: 7484** **After hours:** Contact Arohanui Hospice	

REASON FOR REFERRAL (please ✓): Referral may be appropriate if the patient has active, progressive, advanced disease and the level of palliative care need exceeds that which the current provider can offer.

☐	Uncontrolled or complicated symptoms	☐	Last days of life support: patient, family/whānau, staff/facility
☐	Emotional, psychosocial or existential issues related to the illness	☐	Other:

Patient aware of diagnosis? ☐ Yes ☐ No **Patient aware of prognosis?** ☐ Yes ☐ No	**Patient/advocate consents to referral?** ☐ Yes ☐ No **Whānau/Family/NOK aware of referral?** ☐ Yes ☐ No

BINDING MARGIN – NO WRITING

PATIENT DETAILS/PATIENT LABEL	
DOB:	Patient NHI:
Surname:	First names:
Address:	
Email:	
Ethnicity:	Iwi:
Current location of patient:	Contact phone no:
Usual accommodation (select one): ☐ Private residence (incl. retirement village) ☐ Residential aged care, low level care (level 2 rest home) ☐ Residential aged care, high level care (hospital level) ☐ Other (eg corrections facility):	**Level of current support (select one):** ☐ Lives with others with no care/support provided ☐ Lives alone with no care/support provided ☐ Lives alone with external professional support ☐ Lives with others who provide care/support ☐ Lives with others with external professional support ☐ Not stated/inadequately described/not applicable

NEXT OF KIN/CONTACT PERSON'S DETAILS	
Surname:	First names:
Address:	
Email:	
Phone no:	Relationship:

HEALTH PROFESSIONAL DETAILS (complete if the General Practitioner is not the referrer)	
GP:	Phone no:
Address:	
Consultant(s):	

PLEASE TURN OVER

Name / NHI / DOB:

DISEASE STATUS

Diagnosis:	**Date of diagnosis:**

Site of metastases *(if malignancy)*:

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

Relevant past medical history *(attach a copy of the patient summary if preferred)*:

Current medications *(copy of drug chart is attached: ☐ Yes ☐ No)*:	☐ **Allergies/adverse drug reactions:** ☐ NKDA

Current issues requiring specialist palliative care support

TAHA TINANA | Uncontrolled physical symptoms:

TAHA HINENGARO | Emotional, psychosocial:

TAHA WHĀNAU | Family/whānau social circumstances:

TAHA WAIRUA | Spiritual/existential:

Additional relevant information *(eg barriers to communication – language, hearing)*:

For community patients: *(Please supply most recent hospital discharge summary/OPD letters/other relevant documentation)*: ☐ Attached ☐ Not available

Date of last medical consultation:	

COMMUNITY PATIENTS	**HOSPITAL INPATIENTS**
Name of referring Dr or NP:	**Name of referring Dr or NP:** **If the referrer is not the consultant, please ensure the consultant has given consent (signature implies this has been done).*
GP Practice:	
Contact phone number:	Name of consultant:
Hospital clinic/speciality:	Pager number:
Signature: Date:	Signature: Date:

BINDING MARGIN – NO WRITING