

COMMUNITY HOSPICE PALLIATIVE CARE SERVICES

COMMON REFERRAL FORM



Please indicate service type and provider. (Tick one provider only.)

<input type="checkbox"/> HOME CARE <input type="checkbox"/> Agape Methodist Hospice <input type="checkbox"/> Assisi Hospice <input type="checkbox"/> Dover Park Hospice* <input type="checkbox"/> HCA Hospice Care <input type="checkbox"/> Metta Hospice Care** <input type="checkbox"/> Singapore Cancer Society <input type="checkbox"/> Star PALS	<input type="checkbox"/> IN-PATIENT CARE <input type="checkbox"/> Assisi Hospice <input type="checkbox"/> Bright Vision Hospital <input type="checkbox"/> Dover Park Hospice <input type="checkbox"/> St Joseph's Home	<input type="checkbox"/> DAY CARE <input type="checkbox"/> Assisi Hospice <input type="checkbox"/> HCA Hospice Care
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* Phase 1: Central area (TTSH discharges) only. Please enquire if in doubt.
 **Home care service covers parts of East or North East Singapore only. Please inquire with service.

Please **FAX** this Common Referral Form to the service indicated (Please refer to **ONE** service only.)

Agape Methodist Hospice Fax: 6435-0274 Tel: 6435-0270	HCA Hospice Care/ Star PALS Fax: 6352-2030 Tel: 6251-2561
Assisi Hospice Fax: 6253-5312 Tel: 6832-2650	Metta Hospice Care Fax: 6787-7542 Tel: 6580-4695
Bright Vision Hospital Fax: 6881-3872 Tel: 6248-5755	Singapore Cancer Society Fax: 6221-9575 Tel: 6221-9578
Dover Park Hospice Fax: 6258-9007 Tel: 6500-7272	St Joseph's Home Fax: 6268-4787 Tel: 6268-0482

PATIENT DETAILS (Block letters please. Do not use patient's sticker.)

Full Name: _____ Race: _____ NRIC: _____ Citizenship: _____ Date of Birth: DD / MM / YY Dialect Group: _____ Age: _____ Sex: M / F Religion: _____ Marital Status: Married / Single / Widowed / Separated / Divorced Occupation: _____ <small>Past/Present</small>	Address: _____ Postal Code: _____ Tel: _____ Language(s) spoken: _____ Present Location: Home / Hospital _____ <small>Name of Hospital</small> Ward Tel: _____ Ward/Bed: _____ Expected date of discharge: _____
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KEY FAMILY CONTACT OR MAIN CAREGIVER AT HOME

(If main caregiver is a maid, please indicate the best person to contact.)

Full Name: _____ Relationship: _____ Language(s): _____ Contact No: Home _____ Office _____ Pager / Mobile Phone _____

REFERRAL DETAILS (Please use block letters and full names. Do not use initials.)

Referring Consultant/Registrar/GP: _____ Other Consultants involved: _____ Primary Diagnosis: _____ Sites of Metastases: _____ Prognosis: 0-6 days / 1-7 wks / 2-3 mths / 4-6 mths / 7-12mths / >12mths Is a MSW involved? No / Yes Name of MSW _____ Is patient currently under a hospice service? No / Yes Name of Service: _____ Reason(s) for referral: <input type="checkbox"/> Pain & symptom control <input type="checkbox"/> Psychosocial support <input type="checkbox"/> Shared care <input type="checkbox"/> Terminal care <input type="checkbox"/> Drug titration (specify): _____ <input type="checkbox"/> others (specify): _____	Hospital/Dept: _____ Patient/Family informed of referral: Yes / No Histopathological Diagnosis: Yes / No Date of Diagnosis: _____ (MM/YY) Present Condition: Stable / Deteriorating Hospital Palliative Care team involved? No / Yes
Has patient been informed of diagnosis: Yes / No Has patient been informed of prognosis: Yes / No	Has family been informed of diagnosis: Yes / No Has family been informed of prognosis: Yes / No

Name of Patient: _____

SUMMARY OF MEDICAL HISTORY (Please include relevant investigations e.g. CT / MR I / bone scan)

CURRENT PROBLEMS

1)	4)
2)	5)
3)	6)

CURRENT FUNCTIONAL STATUS

Mental status: Alert / Drowsy / Comatose / Orientated / Confused / Demented

Mobility: Independent / Ambulant with supervision / Ambulant with support / Chair-bound / Bed-bound

Feeding: Independent / Needs supervision / Partially dependent / Totally dependent

Feeding tube (Ryle's/Freka/PEG) Intranasal O₂ (____ L/min) Cope loop (Site: _____) PCN: RT / LT / Bilateral

Tracheostomy Colostomy / Ileostomy Urinary catheter Others _____

CURRENT MEDICATIONS

DRUG ALLERGY: No / Yes _____

Please specify

Name of Drug/Dose/Frequency	Reason Prescribed	Name of Drug/Dose/Frequency	Reason Prescribed
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

SOCIAL BACKGROUND (Please attach Social Report and Means Test if available.)

Family Tree: (Indicate decision maker &/or main carer if known.)

Patient's concerns:

Family's concerns:

Name of doctor completing this form: _____

Date: ____/____/____
DD MM YY

Signature: _____

Pager/Mobile Phone: _____