# *HOSPICE PALLIATIVE CARE SERVICE PROVIDERS*
# COMMON REFERRAL FORM

Please select **one** preferred Care Type and corresponding Service Provider.

SINGAPORE HOSPICE COUNCIL
*Living before Leaving*

**CARE TYPE:**

☐ **HOME CARE**
- ☐ Assisi Hospice
- ☐ Buddhist Compassion Relief Tzu Chi Foundation (Singapore)
- ☐ Dover Park Hospice*
- ☐ HCA Hospice Care
- ☐ Metta Hospice Care**
- ☐ MWS Home Hospice
- ☐ Singapore Cancer Society
- ☐ St Andrew's Community Hospital***
- ☐ Star PALS****
- ☐ Tsao Foundation

**Is this a 'terminal' discharge?** Yes / No

☐ **INPATIENT CARE**
- ☐ Assisi Hospice
- ☐ Bright Vision Hospital
- ☐ Dover Park Hospice
- ☐ St Andrew's Community Hospital
- ☐ St Joseph's Home
- ☐ St Luke's Hospital

☐ **DAY CARE**
- ☐ Assisi Hospice
- ☐ Dover Park Hospice*
- ☐ HCA Hospice Care

To enquire for more details/service:
* Central area (Tan Tock Seng Hospital referrals) only.
** Covers parts of East or North East Singapore only.
*** Supports non-cancer patients in the East of Singapore only.
**** For all referrals to Star PALS, clinicians to complete an additional document attached (PaPaS) for eligibility assessment mandated by MOH.

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

**Full Name:** _____

_____ **Race:** _____

**NRIC:** _____ **Citizenship:** _____

**Date of Birth:** _____ **Dialect Group:** _____
DD / MM / YYYY

**Age:** _____ **Sex:** M / F **Religion:** _____

**Marital Status:** Married / Single / Widowed / Separated / Divorced

**Occupation:** _____
Past/Present

**Address:** _____

_____ **Postal Code:** _____

**Tel:** _____ **Language(s) spoken:** _____

**Present Location:** Home / Hospital _____
Name of Hospital

**Ward Tel:** _____ **Ward/Bed:** _____

**Expected date of discharge:** _____

## KEY FAMILY CONTACT OR MAIN CAREGIVER AT HOME

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

**Full Name:** _____ **Relationship:** _____ **Language(s):** _____

**Contact No: Home** _____ **Office** _____ **Mobile Phone** _____

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

**Referring Consultant/Registrar/GP:** _____ **Hospital/Dept:** _____

**Other Consultants involved:** _____ **Patient/Family informed of referral:** Yes / No

**Primary Diagnosis:** _____ **Histopathological Diagnosis:** Yes / No

**Sites of Metastases:** _____ **Date of Diagnosis:** _____ (MM/YYYY)

**Prognosis:** 0-6 days / 1-7 wks / 2-3 mths / 4-6 mths / 7-12mths / >12mths **Present Condition:** Stable / Deteriorating

**Is a MSW involved?** Yes / No **Name of MSW** _____ **Hospital Palliative Care team involved?** Yes / No

**Is patient currently under a hospice service?** Yes / No **Name of Service:** _____

**Reason(s) for referral:** ☐ Pain & symptom control ☐ Psychosocial support ☐ Shared ☐ Terminal care
☐ Drug titration (specify): _____ ☐ others (specify): _____

**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 $O_2$ (____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 YYYY

**Signature:**_____ **Mobile Phone:** _____

Please **Fax** this form to the selected Service Provider.

| | | | |
|---|---|---|---|
| Assisi Hospice | Fax: 6253 5312 | Tel: 6832 2650 | |
| Bright Vision Hospital | Fax: 6881 3872 | Tel: 6248 5755 | |
| Buddhist Compassion Relief Tzu Chi Foundation (Singapore) | Fax: 6262 6443 | Tel: 6570 2330 | |
| Dover Park Hospice | Fax: 6258 9007 | Tel: 6500 7272 | |
| HCA Hospice Care/ Star PALS | Fax: 6291 1076 | Tel: 6251 2561 | |
| Metta Hospice Care | Fax: 6787 7542 | Tel: 6580 4695 | |
| MWS Home Hospice | Fax: 6435 0274 | Tel: 6435 0270 | |
| Singapore Cancer Society | Fax: 6221 9575 | Tel: 6421 5832 | |
| St Andrew's Community Hospital (home care) | Fax: 6702 1278 | Tel: 6586 8078 | |
| St Andrew's Community Hospital (inpatient care) | Fax: 6586 8004 | Tel: 6586 8000 | |
| St Joseph's Home | Fax: 6252 3227 | Tel: 6268 0482 | |
| St Luke's Hospital | Fax: 6561 3625 | Tel: 6895 3216 | |
| Tsao Foundation | Fax: 6593 9522 | Tel: 6593 9500 | |