COMMUNITY HOSPICE PALLIATIVE CARE SERVICES

SINGAPORE HOSPICE COUNCIL

COMMON REFERRAL FORM

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

☐ **HOME CARE**	☐ **IN-PATIENT CARE**	☐ **DAY CARE**
☐ Agape Methodist Hospice	☐ Assisi Hospice	☐ Assisi Hospice
☐ Assisi Hospice	☐ Bright Vision Hospital	☐ HCA Hospice Care
☐ Dover Park Hospice*	☐ Dover Park Hospice	
☐ HCA Hospice Care	☐ St Joseph's Home & Hospice	
☐ Metta Hospice Care**		
☐ Singapore Cancer Society		
☐ Star PALS		

* 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: 6347-6446**	**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 & Hospice**	**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: ______________________________ (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 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: ______________________ **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/YY)

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

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

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

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

Has patient been informed of diagnosis: Yes / No **Has family been informed of diagnosis:** Yes / No
Has patient been informed of prognosis: 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 YY

Signature: ____ **Pager/Mobile Phone:** ______________________