

# COMMUNITY HOSPICE PALLIATIVE CARE SERVICES

## COMMON REFERRAL FORM



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

<input type="checkbox"/> <b>HOME CARE</b> <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"/> MWS Home Hospice <input type="checkbox"/> Singapore Cancer Society <input type="checkbox"/> Star PALS	<input type="checkbox"/> <b>IN-PATIENT CARE</b> <input type="checkbox"/> Assisi Hospice <input type="checkbox"/> Bright Vision Hospital <input type="checkbox"/> Dover Park Hospice <input type="checkbox"/> St Joseph's Home  <small>* 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.</small>	<input type="checkbox"/> <b>DAY CARE</b> <input type="checkbox"/> Assisi Hospice <input type="checkbox"/> HCA Hospice Care
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Please **FAX** this Common Referral Form to the service indicated (Please refer to **ONE** service only.)

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

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

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

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

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

<b>Referring Consultant/Registrar/GP:</b> _____	<b>Hospital/Dept:</b> _____
<b>Other Consultants involved:</b> _____	<b>Patient/Family informed of referral:</b> Yes / No
<b>Primary Diagnosis:</b> _____	<b>Histopathological Diagnosis:</b> Yes / No
<b>Sites of Metastases:</b> _____	<b>Date of Diagnosis:</b> _____ (MM/YY)
<b>Prognosis:</b> 0-6 days / 1-7 wks / 2-3 mths / 4-6 mths / 7-12mths / >12mths	<b>Present Condition:</b> Stable / Deteriorating
<b>Is a MSW involved?</b> No / Yes <b>Name of MSW</b> _____	<b>Hospital Palliative Care team involved?</b> No / Yes
<b>Is patient currently under a hospice service?</b> No / Yes <b>Name of Service:</b> _____	
<b>Reason(s) for referral:</b> <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): _____	
<b>Has patient been informed of diagnosis:</b> Yes / No	<b>Has family been informed of diagnosis:</b> Yes / No
<b>Has patient been informed of prognosis:</b> Yes / No	<b>Has family been informed of prognosis:</b> 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<sub>2</sub> (\_\_\_\_ 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: \_\_\_\_\_