

# HOSPICE PALLIATIVE CARE SERVICE PROVIDERS COMMON REFERRAL FORM



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

<p><b>CARE TYPE:</b> <input type="checkbox"/> <b>HOME CARE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Assisi Hospice</li> <li><input type="checkbox"/> Buddhist Compassion Relief Tzu Chi Foundation (Singapore)</li> <li><input type="checkbox"/> Dover Park Hospice*</li> <li><input type="checkbox"/> HCA Hospice Care</li> <li><input type="checkbox"/> Metta Hospice Care**</li> <li><input type="checkbox"/> MWS Home Hospice</li> <li><input type="checkbox"/> Singapore Cancer Society</li> <li><input type="checkbox"/> Star PALS***</li> <li><input type="checkbox"/> Tsao Foundation</li> </ul> <p><b>Is this a 'terminal' discharge?</b> Yes / No</p>	<p><input type="checkbox"/> <b>INPATIENT CARE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Assisi Hospice</li> <li><input type="checkbox"/> Bright Vision Hospital</li> <li><input type="checkbox"/> Dover Park Hospice</li> <li><input type="checkbox"/> St Andrew's Community Hospital</li> <li><input type="checkbox"/> St Joseph's Home</li> <li><input type="checkbox"/> St Luke's Hospital</li> </ul> <p><small>To enquire for more details/service: * Central area (Tan Tock Seng Hospital referrals) only. ** Home care service covers parts of East or North East Singapore only. *** For all referrals to Star PALS, clinicians to complete an additional document attached (PaPaS) for eligibility assessment mandated by MOH.</small></p>	<p><input type="checkbox"/> <b>DAY CARE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Assisi Hospice</li> <li><input type="checkbox"/> Dover Park Hospice*</li> <li><input type="checkbox"/> HCA Hospice Care</li> </ul>
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## PATIENT DETAILS (Block letters please. Do not use patient's sticker.)

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

(If main caregiver is a domestic helper, 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>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/YYYY)
<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> Yes / No <b>Name of MSW</b> _____	<b>Hospital Palliative Care team involved?</b> Yes / No
<b>Is patient currently under a hospice service?</b> Yes / No <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 <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 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        Fax: 6262 6443    Tel: 6570 2330  
Tzu Chi Foundation  
(Singapore)  
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   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