Franklin Hospice Referral Form – Community Specialist Palliative Care

Franklin Community Hospice

Once complete email to nurses@franklinhospice.org.nz
For urgent or complex referrals phone 09 238-9376 to handover to a nurse after sending the referral

Referrer Details			
*Referral date		Referrer name	
*Referrer organisation		Contact details	
Patient details			
***Patient aware of referral to Hospice and consented**		**Y**	**N**
*First names		*Surname	
*NHI		*DOB	
Preferred name		*Gender	
*Address			
*1st phone		2nd phone	
*Country of birth		*Ethnicity	
*Language spoken		Communication challenges (deaf, interpreter)	
Home safety concerns (dogs, environment)			
Reason for referral			
*Primary terminal diagnosis			
Secondary diagnosis			
*Symptoms related to palliative diagnosis			
*Relevant medical history			
*Allergies/reactions/risks			
*Phase of illness 1. Non-urgent - visit in 3-7 days 2. Unstable – visit in 48 hours 3. Urgent visit in 24 hours – (phone to speak with a nurse)			
GP – primary doctor			
*Name		*Practice	
*Phone		Address/email	
Next of kin			
Name		Relationship	
Phone		Email	
Social Situation			
Who do they live with?			
Relevant social history (Social concerns/risks)			
Handover notes *Please describe the reason for a hospice referral and palliative specialists needs.			
Recent consult notes and relevant medication attached	**Y**	**N**	