

STANDARD

REFERRAL FORM

Name of applicant _____ (Chinese) _____ (English) HKID No: _____ Sex/Age: _____ Date of Birth: _____ Telephone: _____ (Mobile) _____ (Home) (or please attach gum label)	<u>Next of kin</u> Name: _____ Relationship with applicant: _____ Telephone: _____ (Mobile) _____ (Home) Email address: _____
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1.1 Referral for

<input type="checkbox"/> Palliative Care (in-patient)	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Respite Service
<input type="checkbox"/> Palliative Home Care	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Out-patient Clinic

1.2 Patient location:

Hospital / ward / bed no. _____

Home & address _____

OAH (name & address) _____

2.1 Diagnosis:

For Non-Cancer: Please specify: _____

For Cancer: Primary _____ **Site of Metastasis:** _____

Diagnosis known to patient: Y N Diagnosis known to family: Y N

Patient' consent for referral (Verbal): Y N

Agreed on DNACPR: Y N Not discussed

Any Infectious Disease: Y, please specify: _____ N

2.2 Medical History + Remarks

▲ Please enclose **discharge summary, medical report, investigation report & other confirming evidence.**

3.1 Present Condition (Please delete as appropriate):

Mental State: Alert / Drowsy / Unconscious / Orientated / Disorientated

Mobility: Independently mobile / Mobile with aid / **Wheelchair bound** / Bedbound

Feeding: Independent / Dependent / Tube-feeding

Special Care: Tracheostomy Central line Regular blood transfusion others: _____

3.2 Present Medication & known drug allergy _____

4. Referring Doctor:

Name: _____	Hospital(Ward) / Clinic address: _____
Email address: _____	Tel & Fax No: _____
Signature: _____	Date: _____

5. For internal use:

Date of referral received: _____ Assessment date & staff: _____

Service type: PC/ SCB/ RCS/ HC/ GR/ OR/ QI/ LTC/ RC(D)/ RC(P)

Please fax the completed form and all relevant documents to 2703 5588.

