COMMUNITY HOSPICE PALLIATIVE CARE SERVICES

COMMON REFERRAL FORM

SINGAPORE
HOSPICE
COUNCIL

Please indicate service type anprovider. (Tick one provider only.

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

*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.)

Assisi Hospice	Fax:6253-5312	Tel: 6347-6446
Bright Vision Hospital	Fax:6881-3872	Tel: 6248-5755
Dover Park Hospice	Fax:6258-9007	Tel: 6500-7272
HCA Hospice Care	Fax:6352-2030	Tel: 6251-2561
Metta Hospice Care	Fax: 6787-7542	Tel: 6580-4695
Agape Methodist Hospice	Fax:6478-4765	Tel: 64784766
Singapore Cancer Society	**Fax:6221-9575**	**Tel: 6221-9577**
St Joseph's Home & Hospice	Fax:6268-4787	Tel: 6268-0482

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

Full Name: ____________ Address: ____________

NRIC: ____________ Race: ____________

Date of Birth : ____________ Dialect Group: ____________ Tel: ____________

Age: ____________ Religion: # ____________ Present Location ____________

Marital Status: Married / Single / Widowed / Separated / Divorced Ward Tel: ____________ Ward/Bed: ____________

Occupation: ____________ 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 : ____________

Contact No: Home : ____________ Pager/Mobile Phone : ____________

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

Referring Cosultant/Registrar/GP : ____________ Hospital/Dept: Singapore Cancer Society

Other Consultants involved: ____________ Patient/Family informed of referral: Yes / No

Primary Diagnosis: ____________ Histopathological Diagnosis: Yes / No

Sites of metastases: ____________ Date of Diagnosis: ____________

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

Is a MSW involved ? Yes / No Name of MSW ____________ Hospital Palliative Care Team involved? Yes / No

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

Reason for referral : ☐ Pain & symptom control ☐ Psychosocial support ☐ Shared care ☐ Terminal care

☐ Drug titration (specify) : ____________ ☐ Others ____________

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

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 O2 (L/min) □ Cope loop (Site:___) □ PCN: RT / LT / Bilateral

□ Tracheostomy □ Colostomy / Ileostomy □ Urinary catheter

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: ________________

Signature: ________________ Pager/Mobile Phone: ________________

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