COMMUNITY HOSPICE PALLIATIVE CARE SERVICES

SINGAPORE HOSPICE COUNCIL

COMMON REFERRAL FORM

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

☐ **HOME CARE**
- ☐ Agape Methodist Hospice
- ☐ Assisi Hospice
- ☐ Dover Park Hospice*
- ☐ HCA Hospice Care
- ☐ Metta Hospice Care**
- ☐ Singapore Cancer Society (SCS) Hospice Care
- ☐ Star PALS

☐ **IN-PATIENT CARE**
- ☐ Assisi Hospice
- ☐ Bright Vision Hospital
- ☐ Dover Park Hospice
- ☐ St Joseph's Home & Hospice

☐ **DAY CARE**
- ☐ Assisi Hospice
- ☐ HCA Hospice Care

* 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.

Please **FAX** this Common Referral Form to the service indicated (Please refer to **ONE** service only.)

Agape Methodist Hospice	**Fax: 6435-0270**	**Tel: 6435-0274**	**HCA Hospice Care/ Star PALS**	**Fax: 6352-2030**	**Tel: 6251-2561**
Assisi Hospice	**Fax: 6253-5312**	**Tel: 6347-6446**	**Metta Hospice Care**	**Fax: 6787-7542**	**Tel: 6580-4695**
Bright Vision Hospital	**Fax: 6881-3872**	**Tel: 6248-5755**	**Singapore Cancer Society**		
Dover Park Hospice	**Fax: 6258-9007**	**Tel: 6500-7272**	**(SCS) Hospice Care**	**Fax: 6221-9575**	**Tel: 6421-5832**
Dover Park Hospice	**Fax: 6258-9007**	**Tel: 6500-7272**	**St Joseph's Home & Hospice**	**Fax: 6268-4787**	**Tel: 6268-0482**

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

Full Name: _____

NRIC: _____ **Race:** _____

Date of Birth: ___ /___ /_____ **Dialect Group:** _____
DD MM YY

Age: _____ **Sex: M / F** **Religion:** _____

Marital Status: Married / Single / Widowed / Separated / Divorced

Occupation: _____
Past/Present

Address: _____

_____ **Postal Code:** _____

Tel: _____ **Language(s) spoken:** _____

Present Location: Home / Hospital _____
Name of Hospital

Ward Tel: _____ **Ward/Bed:** _____

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(s):** _____

Contact No: Home _____ **Office** _____ **Pager / Mobile Phone** _____

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

Referring Consultant/Registrar/GP: _____ **Hospital/Dept:** _____

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

Primary Diagnosis: _____ **Histopathological Diagnosis:** Yes / No

Sites of Metastases: _____ **Date of Diagnosis:** _____ (MM/YY)

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

Is a MSW involved? No / Yes **Name of MSW** _____ **Hospital Palliative Care team involved?** No / Yes

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

Reason(s) for referral: ☐ Pain & symptom control ☐ Psychosocial support ☐ Shared care ☐ Terminal care
☐ Drug titration (specify): _____ ☐ others (specify): _____

Has patient been informed of diagnosis: Yes / No
Has patient been informed of prognosis: Yes / No

Has family been informed of diagnosis: 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

1)

2)

3)

4)

5)

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_2 (____ 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:** _____