



# Mercy Hospice Auckland

Te Korowai Atawhai

## REFERRAL FORM

PO Box 47693, Ponsonby, Auckland 1144  
Phone: 09 3615966

61 College Hill, Ponsonby, Auckland 1011  
Fax: 09 3615977

<b>PATIENT'S NAME:</b>	<b>Title:</b> Mr Mrs Miss Ms	<b>NHI:</b>
	<b>Date of Birth:</b>	
<b>Address:</b>	<b>Phone Numbers</b>	
	Home:	
	Mobile:	
	Other:	
<b>Ethnicity:</b>	<b>Name of main carer:</b>	
First language:	Relationship to patient:	
Is an interpreter needed?      Yes <input type="checkbox"/> No <input type="checkbox"/>	Phone number/s:	
<b>GENERAL PRACTITIONER'S NAME:</b>		
Address:		
Telephone number:	Fax number:	
<b>DIAGNOSIS or ACTIVE DISEASE PROCESS (specify):</b>		
Date of diagnosis:		
Basis of diagnosis ( <i>histology, investigations</i> ):		
Main therapies to date:		
Surgery ( <i>operation, date, surgeon, or include op report</i> )		
Chemotherapy/radiotherapy		
Other		
<b>OTHER MEDICAL HISTORY</b>		
<b>CURRENT MEDICATIONS</b>		
<b>DRUG ALLERGIES OR INTOLERANCES</b>		
<b>SOCIAL CIRCUMSTANCES</b>		

**CURRENT NEEDS or REASON FOR THIS REFERRAL:**      Inpatient admission       Community Services

**Patient needs:**

Physical

Other

Psychosocial

**Carer needs:**

Physical

Psychosocial

Other

**Primary Health Team needs:**

**CURRENT CIRCUMSTANCES:**

	Patient aware? Yes/No	Family aware? Yes/No
Awareness of diagnosis		
Awareness of prognosis		
Understanding of palliative care approach		

**OTHER SERVICES CURRENT INVOLVED:**

District Nurses	Yes	No	
Oncology District Nurses	Yes	No	
Cancer Society	Yes	No	
Other Hospice	Yes	No	(if yes, specify) .....
Social Worker	Yes	No	(if yes, specify) .....
Interpreter	Yes	No	(if yes, give name & phone) .....
Other 1	Yes	No	(if yes, specify) .....
Other 2	Yes	No	(if yes, specify) .....

**CHECKLIST:**

Patient is aware of and has consented to referral to Mercy Hospice Auckland.

**Please include the following where applicable; indicate with a tick or 'N/A':**

Most recent correspondence from:

- Primary Specialist
- Other Specialist (specify)

Documentation confirming basis of diagnosis       Most recent radiology reports

Most recent blood test results       Operation report

**THIS REFERRAL CANNOT BE ACTIONED BY OUR TEAM IF:**

1. The General Practitioner has not been notified
2. There is insufficient supporting information

**IF THIS REFERRAL NEEDS URGENT ATTENTION (ie initial contact within 24-48 hours)  
PLEASE RING the Community Charge Nurse on 361 5966 to discuss, as well as FAX it to 361 5977.**

**If you want to discuss acute admission to the Inpatient Unit,  
please ring the Admitting Doctor on 361 5966.**

YOUR NAME ..... DESIGNATION .....

SIGNATURE ..... TELEPHONE NUMBER .....

TODAY'S DATE ..... AND FAX NUMBER .....

If you are not the General Practitioner, please give the date the GP was notified: .....

If you are the GP, please give details of **AFTER HOURS MEDICAL SERVICE:**

..... (Name)      ..... (Telephone number)

**THANK YOU ☺ We will fax you notification of receipt of this referral in 1 working day.**