HOSPICE REFERRAL FORM

I. Please tick choice of hospice

Inpatient Hospice:

☐ **Pure Lotus Hospice of Compassion**
73, Jalan Utama 10460, Penang
Tel / Fax : 04-2295481

Home Care:

☐ **Charis Hospice (only covers Penang Island)**
26 & 28, Lintang Paya Terubong 3, 11060 Penang
Tel : 04-8279668 Fax : 04-8279667

☐ **Hospice at Home Programme (covers State of Penang)**
Penang Hospice Society
250-A, Jalan Air Itam, 10460 Penang.
Tel: 04-2284140 Fax : 04-2264676

II Patient Data

Name: _____ IC No.: _____

Sex: M ☐ F ☐ Age: _____ Religion: _____

Handphone: _____ House Phone: _____

Address: _____

_____

Languages Spoken : _____

Next of Kin: _____ Tel: _____

Diagnosis & present problems : _____

_____

_____

Latest lab & imaging reports : _____

_____

_____

Treatment / Medication : _____

_____

_____

If follow up required at hospital, give date _____

	Patient	**Family**
Been told the diagnosis?	Yes / No	Yes / No
Been told the prognosis?	Yes / No	Yes / No
Aware of the referral?	Yes / No	Yes / No

III. Referring Doctor:_____ Tel:_____

(BLOCK LETTERS)

Clinic/Ward: _____

Referring Doctor's signature: _____ Date:_____

Notes:

1. Please confirm patient's telephone and address is correct.
2. Either a) fax form to selected hospice or
   b) call to give patient's particulars.
3. This form can be given to patient
4. Services are free
5. Advise patient/family to call hospice on arrival at home
6. Suitable patients are those with Stage 3 & 4 cancers. Others are on case to case basis (contact hospice for more info)