HOSPICE REFERRAL FORM

Please tick choice of hospice				
Inpatient Hospice:		me Care:	. ,	
Pure Lotus Hospice of			ice (only covers Pe	
73, Jalan Utama 10460, Tel: 04-2295481/011-55			ing Paya Terubong 3	
Tel: 04-2295481/011-55095481 Tel: 04-8279668, 011-1246675 Email: lyanshih@gmail.com Email: charishospice@gmail.com				
Hospice at H	lome Programme: (cov Penang Hospice Soc		nang),	
	250-A, Jalan Air Itam,			
	Tel: 04-2284140 Fax:			
	Email: penanghospice	society@gmail.d	<u>com</u>	
II <u>Patient Data</u>				
ii <u>Fatielit Data</u>				
Name:	IC No.:			
Sex: M F Age:	Religion:	N	arital Status:	
Patient's Handphone:		_ House Phone	:	
		Relationship: Tel:		
Person to Contact:	Relationship: Tel:		Tel:	
Address:				
Languages Spoken :				
Diagnosis & present problems :				
2				
Comorbidity:				
Latest lab & imaging reports :				
Treatment / Medication :				
Patient currently at: Hospital Ward		·		/Home
f follow up required at hospital, give date _			Comily	
Doon told the diagnosis?		<u>:ient</u> s / No	<u>Family</u> Yes / No	
Been told the diagnosis? Been told the prognosis?		s / No s / No	Yes / No	
Aware of the referral?		s / No s / No	Yes / No	
III. Referring Doctor:(BLOCK LI	ETTERS)	I el:		
Clinic:	LIILIO J			
		_		
Referring Doctor's signature:)ate:	

- Either a) fax/WhatsApp/email form to selected hospice or b) call to give patient's particulars. This form can be given to patient

- Advise patient/family to call hospice on arrival at home
 Suitable patients are those with Stage 3 & 4 cancers. Others are on case to case basis (contact hospice for more info)