Totara hospice
Living Every Moment

TOTARA HOSPICE PATIENT REFERRAL FORM

Patient must give consent for referral

Fax: 096400292 OR Email: clinicaladmin@hospice.co.nz

Patient details (or attach label):

Name | DOB | NHI

Address

Ethnicity

Phone number

Email

New Zealand resident ☐ Yes ☐ No ☐ Unknown

Next of kin (or first contact details):

Relationship to patient

Name | Phone number

Family Practice:

Clinic Name

GP

Phone Number

Diagnosis and relevant medical history:

Medications:

Presenting reason for referral:

Physical issues

Psychological

Social

Carer

Community ☐ Inpatient ☐ Outpatient clinic ☐

Is the patient aware of the diagnosis and likely prognosis? (Y)/(N)

Other services involved:

- District Nursing ☐
- NASC/HBSS ☐
- Social Work ☐
- Occupational Therapy ☐
- Physiotherapy ☐
- Dietetics ☐
- Interpreter ☐

Other

If your referral is urgent please phone the hospice directly on 09 640 0025 to discuss with the community or inpatient team.

Please fax or email corroborating documents, letters of discharge, blood tests and clinic letters to support the referral.

Name and designation of referrer:

Contact details of referrer:

Please ensure that patient has agreed for Hospice involvement:

◉ **Yes** ○ **No**