Hopewell Hospice

Clinical Record Manual

Clinical Referral Information

Approved: Hospice Manager/CNC
Effective Date: 07/2015
Review Date: 05/2016
Updated 06/2015
Code: CR03 FO 1.4.1

Affix Resident Label

Referral/Admission Form

CR03

Hopewell Hospice
PO Box 1290 Runaway Bay 4216
P: 07 5563 2930 **F:** 07 5574 6871

Referral Date: _____/_____/_____ **Admission Date:** _____/_____/_____

Resident Details (Complete All Fields where Possible and Print Clearly)			
Surname:	**Title:**	**Marital Status**:	
First Name:	**Preferred Name:**		**Gender:**
Date of Birth:	**Country of Birth:**		
Home Address:			**Postcode:**
Home Phone:	**Religion:**	**AB /TI Descent:** Yes / No	
Email:			

Medical Details (Complete All Fields where Possible, Circle where Required and Print Clearly)			
Transferred From:	Hospital	Home (As Above)	**Other:**
Name of Hospital:			**Phone:**
Diagnosis:			**Date Diagnosed:**
Allergies:			
Has the patient had an ACAT assessment? Yes / No Outcome:			
Does the Patient have Dementia? Yes / No	**Symptoms** (Wander or Confused?)**:**		
Does the Patient have an Advanced Health Directive? Yes / No / Unsure			
Referred By:			**Phone:**
Home GP:			**Phone:**
Specialist:			**Phone:**

Authorised Guardian / Next of Kin (Complete All Fields where Possible, Circle where Required and Print Clearly)		
Name:	**Relationship:**	**EPOA** : Yes / No
Home Address:		**Postcode:**
Phone H:	**Mobile:**	**Email:**

Authorised Guardian / Next of Kin (Complete All Fields where Possible, Circle where Required and Print Clearly)		
Name:	**Relationship:**	**EPOA** : Yes / No
Home Address:		**Postcode:**
Phone H:	**Mobile:**	**Email:**

REFERRAL ADMISSION FORM

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Clinical Referral Form

CR03

PLEASE PRINT CLEARLY

Reason for Admission: ☐ Palliative Care ☐ Respite **Pacemaker** Yes / No **Other Devices** Yes / No

Summary of Condition Including Other Diagnosis and Treatments

☐ **Phase** ☐ **AKPS** (Karnofsky) **Date Assessed:**

Any Other Significant Treatment

Chemotherapy: Yes/No Type:

: Date last cycle/dose **Ongoing/Current: Yes/No**

Radiation Treatment: Yes/No Type:

: Date last cycle/dose **Ongoing/Current: Yes/No**

Is the patient currently receiving treatment in a clinical trial: Yes/No Type:

: Date last cycle/dose

: Ongoing/Current: Yes/No

Has the patient a history of a notifiable infection/disease? Yes/No Type:

Has a risk assessment for CJD been documented? Yes/No Result:

Does the patient have a diagnosed infection on recent assessment? Yes/No Type:

Has the patient been admitted to a overseas hospital within the last 12 months? Yes/No

If Yes: Where_____ **When:**_____

Has the patient been a resident in a overseas Aged Care Facility within the last 12 months? Yes/No

If Yes: Where_____ **When:**_____

CLINICAL REFERRAL FORM

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Patient's understanding of their Illness?		
Prognosis (in weeks/months)		
Prognosis Discussed with Patient?	Yes / No	Fully aware / Unsure
Has 'Not For Resuscitation' been Discussed and Documented?	Yes / No	Fully aware / Unsure

Current Pain Management Regime and Breakthrough Medication

Other Medications

Current Bowel Regime:		**Bowels Last Opened:**
Continent: Yes/No **Incontinent: Bladder Yes/No** **: Bowels Yes/No**	**IDC: Yes/No Type:** **Date Inserted:**	**Skin Integrity/Wounds:** **Pressure Injury Stage:**
Mobility:		**Aids Used:**
Nutritional/Dietary Needs:		
Social & Support History:	**Is there any social dynamics that are relevant to the patient's care?**	

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Additional Information: