

Clinical Referral - Hopewell Hospice

Affix Resident Label

Hopewell Hospice
88 Allied Drive Arundel

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P: 07 5625 1930 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: | | |
| Email: | | | |
| AB/TI Descent: <input type="checkbox"/> Aboriginal but not Torres Strait Islander origin <input type="checkbox"/> Not stated/inadequately described | | | |
| <input type="checkbox"/> Torres Strait Islander by not Aboriginal origin <input type="checkbox"/> Both Aboriginal & Torres Strait Islander origin | | | |
| <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander origin | | | |

| Medical Details (Complete all fields where possible, tick where required and print clearly) | | | |
|---|-----------------------------------|--|-----------------|
| Transferred from: | <input type="checkbox"/> Hospital | <input type="checkbox"/> Home (as above) | Other: |
| Name of Hospital: | | | Phone: |
| Diagnosis: | | | Date Diagnosed: |
| Allergies: | | | |
| Has the patient had an ACAT assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No Outcome: | | | |
| Does the Patient have an Advanced Health Directive? | | Does the Patient have a Statement of Choices? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | |
| Referred: | | | |
| Home GP: | | | Phone: |
| Specialist: | | | Phone: |
| Community Nursing Service involved: | | | Phone: |

| Authorised Guardian / Next of Kin (Complete all fields where possible, tick where required and print clearly) | | | |
|---|---------------|--|-----------|
| Name: | Relationship: | EPOA: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Home Address: | | | Postcode: |
| Phone H: | Mobile: | Email: | |

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PLEASE PRINT CLEARLY

| Summary of condition including other diagnosis and treatments | | | |
|---|-------------------------------|----------------------------------|----------------|
| | | | |
| Phase <input type="checkbox"/> | AKPS <input type="checkbox"/> | RUG-ADL <input type="checkbox"/> | Date Assessed: |

| Any other significant treatment | |
|---|---|
| Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: |
| Date last cycle/dose: | Ongoing/Current: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: |
| Date last cycle/dose: | Ongoing/Current: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the patient currently receiving treatment in a clinical trial: <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: |
| Date last cycle/dose: | |
| Ongoing/Current: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Has the patient a history of a notifiable infection/disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: | |
| Has a risk assessment for CJD been documented? <input type="checkbox"/> Yes <input type="checkbox"/> No Result: | |
| Does the patient have a diagnosed infection n recent assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: | |
| Has the patient been admitted to an overseas hospital within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If Yes: Where _____ When: _____ | |
| Does the Patient have any implanted devices e.g.: Pacemaker, Intrathecal Pump, Spinal Cord Stimulator | |
| If Yes: Type of device _____ Location: _____ | |



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Additional Information: