HOSPICE REFERRAL FORM

I Please tick choice of hospice

Inpatient Hospice:

☐ **Pure Lotus Hospice of Compassion**
73, Jalan Utama 10460, Penang
Tel: 04-2295481/011-55095481
Email: lyanshih@gmail.com

Home Care:

☐ **Charis Hospice (only covers Penang Island)**
26 & 28, Lintang Paya Terubong 3, 11060 Penang
Tel: 04-8279668, Whatsapp : 011-12466757
Email: charishospice@gmail.com

Hospice at Home Programme: (covers State of Penang),

☐ **Penang Hospice Society**
250-A, Jalan Air Itam, 10460 Penang
Tel: 04-2284140 Fax: 04-2264676
Email: penanghospicesociety@gmail.com

II Patient Data

Name: _____ IC No.: _____

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

Patient's Handphone: _____ House Phone: _____
Person to Contact: _____ Relationship: _____ Tel: _____
Person to Contact: _____ Relationship: _____ Tel: _____
Address: _____
_____

Languages Spoken : _____

Diagnosis & present problems : _____
_____
_____

Comorbidity : _____
_____
_____

Latest lab & imaging reports : _____
_____
_____

Treatment / Medication : _____
_____
_____

Patient currently at: Hospital Ward_____/Nursing Home _____/Home
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: _____

Referring Doctor's signature: _____ Date:_____

Notes:

1. Please confirm patient's telephone and address is correct.
2. Either a) fax/WhatsApp/email 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)