PATIENT REFERRAL FORM

THIS FORM IS TO BE COMPLETED FREE OF CHARGE

NAIROBI HOSPICE

P. O. Box 74818, 00200-City Sq.
NAIROBI, KENYA
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Website: www.nairobihospice.or.ke

PLEASE NOTE ONLY IN EXCEPTIONAL CIRCUMSTANCES SHOULD PATIENTS BE REFERRED WHO ARE NOT AWARE OF THEIR DIAGNOSIS

PATIENTS No.

Nairobi Hospice Ref No:

Patient Name: Age: Sex:

Address

Telephone No:

Consultant(s) in charge of patient:

Diagnosis:

Date of diagnosis

Primary site:

Secondary deposits:

How was diagnosis confirmed?
(Please attach a copy of Histology Report)

Reason(s) for referral:

What has the patient been told about the diagnosis ?

What has the family been told?

What is the expected prognosis?

Has the patient been informed of the referral? YES/NO
If not please discuss with a member of the Hospice Team before referral.

"Put life into their Days, not just Days into their Life"

Registered Charitable Trust No. 42458

PLEASE TURN OVER

Current treatment:

Previous treatment

Surgery (with details and dates)

Radiotherapy (with details and dates)

Chemotherapy (with details and dates)

Hormone therapy: (with details and dates)

Past medical history:

Where can the patient be seen?
In Hospital At Home At the Hospice

For Hospital Patients Only:.

Hospital: Date of Admission Ward:

File No Date of Discharge:

Does referring Doctor wish to

1.Share care with the Hospice doctor? YES/ NO

2.Consultation only with Hospice doctor? YES/ NO

3.Have Hospice Palliative Care team take over care? YES/ NO

Patient's /Relative's Signature.....

Referring doctor (Please Print)

Name.....

Address:.....

Telephone No .....

Signature..... Date:.....