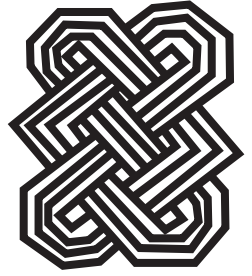


PATIENT REFERRAL FORM

***THIS FORM IS TO BE COMPLETED
FREE OF CHARGE***

NAIROBI HOSPICE

P. O. Box 74818, 00200-City Sq.
NAIROBI, KENYA
Tel: 2719383, 2712361, 2726502
2726300 Ext: 44000
Fax: 2722212
Email: info@nairobihospice.or.ke
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:

How was diagnosis confirmed?

(Please attach a copy of Histology Report)

Secondary deposits:

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:.....