PATIENT REFERRAL FORM

NAIROBI HOSPICE

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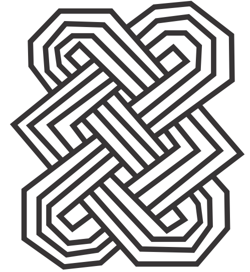

THIS FORM IS TO BE COMPLETED FREE OF CHARGE

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

PATIENTS 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/ or Eliza test Results)

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

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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: ____________ Ward__________ Date of Admission:________________

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 ____________________

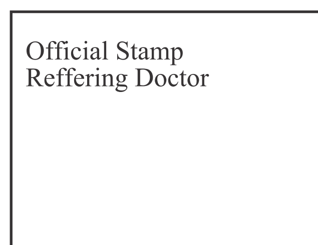
3.Have Hospice Palliative Care team take over care? YES/ NO____________________

Patient’s /Relative’s Names:____________________________________

Signature:____________________________________

Referring doctor (Please Print)

Name..


Official Stamp
Reffering Doctor

Address:...

Telephone No ....

Signature.. Date:...