HOSPITAL AUTHORITY

Standard Referral Form for Palliative Care

(Please read the 'points to note' overleaf before completing this form.)

To: _____ Hosp/Inst

Patient's Particulars (Address and Tel no. are essential)

Name : _____
ID No. : _____
Tel No. : _____
Address : _____
_____
_____

Please either affix patient's FULL gum label or fill in patient's particulars at the left.

1.1 Referral for
- ☐Palliative In-patient Care
- ☐Palliative Consultative Service
- ☐Palliative Out-patient Service
- ☐Palliative Day Service
- ☐Palliative Home Care (Please specify the expected date of discharge: _____)

1.2 Where is the patient at present?

Home _____ Hospital (Please specify) _____ Others (please specify) _____

2.1 Diagnosis:

For Cancer: Primary: _____ Site of Metastasis: _____

For Non-Cancer: (Please specify) _____

Diagnosis known to patient:	☐Y	☐N	Diagnosis known to family: ☐Y	☐N
Patient's consent for referral (Verbal):	☐Y	☐N		
Agreed on DNACPR order/AD:	☐Y	☐N	☐Not discussed	
Any Infectious Disease:	☐Y	☐N		

If yes , please specify: _____

2.2 Medical History (Please provide key information)

_____
_____
_____

3.1 Present Condition: (Please delete as appropriate)

Mental State: Alert / Drowsy / Unconscious / Orientated / Disorientated
Mobility: Independently mobile / Mobile with aid / Chairbound / Bedbound
Feeding: Independent / Dependent / Tube-feeding
Other Relevant Points _____
_____

3.2 Present Medication & Dosage (Refer to CMS, please write down any drugs not documented in CMS) _____

_____
_____

4.1 Reason(s) for Referral

☐Pain and Symptoms Control ☐Psychosocial/spiritual Care ☐Care for the Imminently Dying

Others _____

4.2 Will the referring unit continue to follow up the case Y☐ N☐

If the answer is yes, please provide the date of next follow up _____ (Date/Month/Year)

4.3 Please enclose **Pathology report/medical report/discharge summary/other confirming evidence** (Only if data cannot be retrieved from CMS).

5 Remarks _____

6 Referring Doctor: _____ (Block Letter) _____ (Signature)

Hospital/Unit: _____ Tel & Fax No. of Referring Doctor: _____ (Tel) _____ (Fax)

Date: _____

For Palliative Care Unit:

7.1 Date of referral received: _____ Date of assessment: _____

7.2 Remarks: _____ Sign: _____

POINTS TO NOTE FOR THE COMPLETION OF THE STANDARD REFERRAL FORM FOR PALLIATIVE CARE

1. This form is to be filled by the referring doctor and faxed to the Palliative Care Unit. Please attach case summary and relevant documents.

2. If the referring unit has referred the patient to more than one palliative care unit, it is required to cancel the referral when the patient is accepted by any one palliative care unit.

3. Please fill in all patient's information. Address and telephone no. are essential.

4. Inpatient referral should be made by doctor in-charge of the patient.

5. Referral criteria for different types of palliative care services for patients with life-threatening and life-limiting conditions:

1. **Inpatient**	• Patients with complex symptoms and psychosocial problems that require day-to-day medical intervention • Patients are clinically unstable requiring inpatient care • Patients are imminently dying
2. **Consultative Service (In-patient)**	• Patients in non-palliative care setting who develop severe or complex symptoms and face medico-psycho-social needs and require palliative care but are still under the care of the parent team • Patients who require palliative care but are psychologically not ready for inpatient palliative care referral or physically not fit for transfer to palliative care inpatient bed
3. **Outpatient**	• Patients with symptoms or complicated disease-related psychosocial problems that require specialist care and can be managed in an outpatient clinic setting • Continuity of palliative care for discharged patient
4. **Day Service**	• Patients with multiple problems which symptoms are recurrent or chronic (e.g.: breathlessness, fatigue, lymphoedema) requiring one-stop multidisciplinary consultation and treatment in ambulatory setting • Patients suffering from recurrent symptoms (e.g. Abdominal drainage / tapping, blood transfusion) requiring repeated interventional therapeutic procedure(s)
5. **Home Care**	• Patients requiring more intensive symptom monitoring beyond outpatient clinic setting • Patients having difficulties commuting to the hospital/ clinic to receive ambulatory treatment • Patients / families requiring mild to moderate psychosocial intervention • Families requiring support to maintain patients at home • Discharged patients requiring continuity of care at home setting • Bereavement care • Support patients to die in place as appropriate if it is patients/families' preference

* Remarks: amended on June 2020