BOLAND HOSPICE

Community Base Services Referral Form

Date: ___________________

1. PERSONAL DETAILS

Name: ____

Birth Date: ______________________ Sex: (M) or (F)

Address: ____

______________________ Postal Code: _______________

Tel No: ______________________ Religion: _______________

Language: ____

Next of kin: ______________________ Tel No: _______________

2. HOSPITAL DETAILS

Name of Institution: ___________________________________

Diagnosis: ____

Folder No: ______________________ Ward: _______________

Admission Date: ______________________ discharge Date: _______________

3. MEDICAL SUMMARY

Final Diagnosis: ___________________________________

Weight: ______________________ Height: _______________

Allergies: ____

Reports Attached: (Y) or (N)

Referred to CHC: ___________________________________

4. Please tick all that apply:

Service	☐	Service	☐
Physiotherapy		Dressings/ Wound care	
Occupational Therapy		Pressure Care	
Speech Therapy		Nosogastic Feed	
Dietician		Catheter Care	
Social Worker		Incontinence Care	
Grant		Stoma Care	
Psychiatric Follow Ups		Tracheotomy Care	
Educational Needs		Postnatal Care	
Family Planning		Rehabilitation	
Developmental Screening		Equipment Supplies	
Social Support		Other:	
Hospice/ Frail Care			

5. Please Specify if you have Indicated any of the above: ______________________

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6. Discharge Medication: ___________________________________

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Client Assessment

			Institution	NGO
Activities of Daily Living				
☐	Moves without help	1		
☐	Moves with Help	2		
☐	Bedridden, Unable to move Without help	3		
Personal Hygiene: Toileting				
☐	Able to help self	1		
☐	Needs help	2		
☐	Unable to help self	3		
Washing				
☐	Able to help self	1		
☐	Needs help	2		
☐	Unable to help self	3		
Mouth Care				
☐	Able to help self	1		
☐	Needs help	2		
☐	Unable to help self	3		
Shaving				
☐	Able to help self	1		
☐	Needs help	2		
☐	Unable to help self	3		
Hair Care				
☐	Able to help self	1		
☐	Needs help	2		
☐	Unable to help self	3		
Eating & Drinking Capabilities				
☐	Able to eat self	1		
☐	Requires Help	2		
☐	Unable to eat or drink	3		
Dressing				
☐	Dresses and Undresses without help	1		
☐	Dresses and Undresses with help/Needs a reminder to dress/ undress	2		
☐	Unable to Dress and Undress	3		
Medication				
☐	Takes Medication without help	1		
☐	Requires help with Medication	2		
☐	Unable to take own Medication	3		

Mental Status: Orientation

- [ ] knows Time, place and people around him/ her — 1
- [ ] Needs help — 2
- [ ] Unable to tell date, time or place — 3

Memory

- [ ] Memory good/ No help needed — 1
- [ ] Sometimes forgets/ Needs help — 2
- [ ] Serious loss of memory — 3

Ability to Understand Instruction/ Comprehension

- [ ] Able to understand when asked to do something — 1
- [ ] Needs help to understand/ Comprehend — 2
- [ ] Unable to understand — 3

Coping Skills

- [ ] Able to cope with their emotions — 1
- [ ] Requires help when coping with emotions — 2
- [ ] Unable to cope with emotions — 3

Behaviour

- [ ] No difficult behaviour — 1
- [ ] Sometimes Behavioural problems — 2
- [ ] Constant behavioural behaviour — 3

Score	Category	Category Description	Home based Package
14	1	Independent	Screen Train Family Referral to Other Disciplines/ Support Groups
15-28	2	Require Minimum Assistance	Moderate HBC Needed
29-42	3	Requires Maximum Assistance	Intense HBC Needed

Date: _____________

Assessor

Print Name: ____

Contact Details: ____

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