Boland Hospice

Intermediate Care Facility Inpatient Unit Referral Form

Date: ____________

Patient's name: ____

Date of Birth: ____

Address: ____

____

____

Tel Nr: ____

Next of Kin: ____

Medical Aid: ____

MEDICAL

To be completed by Medical Practitioner in Conjunction with Patient and/ or Patient family.

1. From what disease is the patient suffering? ________________________________

   ____
2. Duration? ____
3. Primary Focus of disease – Please specify as closely as possible: ______________

   ____
4. Secondary deposits – Where? ____

   ____
5. Has the patient undergone any operations? YES / NO

   If YES, please specify: ____

   ____
6. Has Patient undergone any Radiation? If so, state institution, region of body radiated and dates:____

   ____
7. Has Patient had any Cytotonic or hormone therapy? Please give Details.

   ____

   ____
8. Does the Patient have any allergies? Please specify.

   ____

   ____
9. What is the present condition of the patient?
   a) **Pain**: ____
   b) **Other severe symptoms**: ________________________________
   c) **Mental State**:____
   d) **Incontinence Bladder**: ____
   e) **Performance Status**: **0**- Normal **1**- Symptom ambulatory

      (Please Circle) **3**- In Bed (50% of time) **4**- Bedridden

10. HIV and TB Diagnosis and treatment
On ARV's: No or Yes
If yes, last viral load: ____________________ Date: __________________
Date Started: _________________

TB: Reg1____ 2____
Reg Started ____
Recent Sputem: ____

11. For all Patients
General examination and base line

____
J A C C O L:
____
Respiratory:
____
CVS
____
Abdoman:
____
____
____

12. Recent Laboratory Results:

____
____
____
____

13. Current Medical Treatment:
a)____
b)____
c)____
d)____
c)____
d)____
e)____
f)____

13. The Hospice Team Comprises of a Nursing Sister, Doctor and Home Base Carers. May we have your Permission for any member of the team to visit and advise the patient?

____

14. Attached is the permission form that the patient or the family member must sign to give permission for the admission of the patient to the Intermediate Care Facility Unit or Home Base Care program.

Referring Hospital: ____

Consultant under Whom admitted at referring Hospital:

____

Date of next Hospital Appointment: __________________________________

Signature of referring Doctor: _______________________________________

(Please print name in Block Capitals)

Address or Hospital: ____

____

____

Tel Nr: ________________________ Date: ________________________