Cranford hospice hawke's bay Living Every Moment	**SPECIALIST PALLIATIVE CARE REFERRAL FORM** For patients in the community	HAWKE'S BAY District Health Board

Referral Date:		
Name of Referrer: **Phone:**	Patients GP: Phone:	Consultant: Phone:
URGENT ☐	If contact required in less than 24 hours or out of office hours	**Telephone: 06 878 7047**
ROUTINE☐	Contact will be made within 2 working days of receipt Monday to Friday 0830 – 1630	**Fax Form: 06 878 3799**
PATIENT CONSENT TO REFERRAL: YES ☐ **NO** ☐		
NB: For admission to Cranford Hospice inpatient unit, please also telephone Cranford Hospice and speak to the inpatient unit Team Leader		

Name:	**NHI:**
Address:	
Phone:	
Main Support Person: **Relationship:** **Phone:**	
Patient/Family aware of Referral: Y / N	**Patient/Family aware of Prognosis: Y / N**

REASON FOR REFERRAL:	
Please specify if only specific elements of service are requested e.g. syringe driver support, Palliative Medicine outpatient appointment, counselling.	
PRIMARY DIAGNOSIS:	**DATE OF DIAGNOSIS:**
TREATMENT RECEIVED:	
PAST MEDICAL HISTORY/ COMORBIDITIES:	
CURRENT MEDICATIONS:	

OTHER HEALTH CARE PROFESSIONALS INVOLVED:

OTHER INFORMATION:
Please send relevant correspondence / results

OUTCOME: