Nelson Tasman Hospice
to care always

Please fax to:
If out of hours / weekends please fax to (03) 546 3951
Post to: P O Box 283, Nelson 7040

Referral Form

Urgency: ☐ Within 24 hrs ☐ 24 – 72 hrs ☐ Non urgent

Patient Details		
Surname:		First Names:
Address		Phone:
		Email:
NHI:	DOB:	Ethnicity:
Patient meets all 5 points of the Specialist Palliative Care Criteria: ☐ Patient has active, progressive, advanced disease ☐ Patient has a level of need that exceeds resources of primary care provider ☐ Patient agrees to referral if competent to do so (or advocate agrees on their behalf) ☐ Patient has NZ residency or reciprocal rights ☐ Patient is registered with a local primary health provider		**Usual accommodation (please select one):** ☐ Private residence (incl retirement village) ☐ Residential aged care, low level care (rest home) ☐ Residential aged care, high level care (hospital level) ☐ Other _____

Next of Kin Details	
Surname:	First Names:
Address:	Phone:
Relationship:	Email:

Clinical Details	
Diagnosis:	
	Date of Diagnosis:
Past Medical History:	
Recent Observations/Tests:	
Current Problems/Symptoms:	

Clinical Details Contd
Safety/Risk Issues:
Relevant Social History:
Medications (alternatively attach copy of drug chart):
Allergies/Adverse Drug reactions:
Additional Information:

Referral

Reason for Referral:

☐ Symptom Management ☐ Psychosocial Support ☐ Consult

☐ Family/Whānau Support ☐ End Stage Care ☐ Other – specify _____

Other Services Involved:

☐ District Nurses ☐ Oncology Nurses ☐ Social Worker

☐ Occupational Therapy ☐ Physiotherapy ☐ Māori Health Provider

☐ Home Support Agency (please state):

☐ Other:

Health Professional Details	
GP:	Consultant:
Name of Practice:	DHB Dept:
Referred by:	Designation:
Signature:	Date: