Hopewell Hospice
Healthcare with Heart

wesley mission QUEENSLAND

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Affix Resident Label

Referral/Admission Form

Hopewell Hospice
PO Box 1290 Runaway Bay 4216

Hopewell Hospice
***P:** 07 5625 1900 **F:** 07 5574 6871*

Referral Date: _____/_____/_____

Admission Date: _____/_____/_____

Resident Details (Complete All Fields where Possible and Print Clearly)		
Surname:	**Title:**	**Marital Status**:
First Name:	**Preferred Name:**	**Gender:**
Date of Birth:	**Country of Birth:**	
Home Address:		**Postcode:**
Home Phone:	**Religion:**	**AB /TI Descent:** Yes / No
Email:		

Medical Details (Complete All Fields where Possible, Circle where Required and Print Clearly)			
Transferred From:	Hospital	Home (As Above)	**Other:**
Name of Hospital:			**Phone:**
Diagnosis:			**Date Diagnosed:**
Allergies:			
Has the patient had an ACAT assessment? Yes / No Outcome:			
Does the Patient have an Advanced Health Directive? **Yes / No / Unsure**		Does the Patient have a Statement of Choices? **Yes / No / Unsure**	
Referred By:			
Home GP:			**Phone:**
Specialist:			**Phone:**
Community Nursing Service involved:			**Phone:**

Authorised Guardian / Next of Kin (Complete All Fields where Possible, Circle where Required and Print Clearly)		
Name:	**Relationship:**	**EPOA** : Yes / No
Home Address:		**Postcode:**
Phone H:	**Mobile:**	**Email:**

REFERRAL ADMISSION FORM

Electronic documents are controlled documents.
Printed versions are uncontrolled and valid only at time of printing

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Clinical Referral Form

PLEASE PRINT CLEARLY

Summary of Condition Including Other Diagnosis and Treatments

Phase ☐ **AKPS** (Karnofsky) ☐ RUG-ADL ☐ **Date Assessed:**

Any Other Significant Treatment

Chemotherapy: Yes/No Type:

: Date last cycle/dose **Ongoing/Current: Yes/No**

Radiation Treatment: Yes/No Type:

: Date last cycle/dose **Ongoing/Current: Yes/No**

Is the patient currently receiving treatment in a clinical trial: Yes/No Type:

: Date last cycle/dose

: Ongoing/Current: Yes/No

Has the patient a history of a notifiable infection/disease? Yes/No Type:

Has a risk assessment for CJD been documented? Yes/No Result:

Does the patient have a diagnosed infection on recent assessment? Yes/No Type:

Has the patient been admitted to an overseas hospital within the last 12 months? Yes/No

If Yes: Where_____ **When:**_____

Has the patient been a resident in a overseas Aged Care Facility within the last 12 months? Yes/No

If Yes: Where_____ **When:**_____

Does the Patient have any implanted devices eg: Pacemaker, Intrathecal Pump, Spinal Cord Stimulator

If Yes: Type of device_____ **Location:**

CLINICAL REFERRAL FORM

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Patient understanding of illness	
Prognosis	< 1 week ☐ < 3 months ☐ 3-6 months ☐ 6-12 months ☐
Patients understanding prognosis	Yes / No fully aware / Unsure
Has 'Not for Resuscitation' been Discussed and Documented?	Yes / No fully aware / unsure

Clinical Details / Symptom Management / Medication Regime

Nursing Considerations		
Current Bowel Regime:		**Bowels Last Opened:**
Continent: Yes/No **Incontinent: Bladder Yes/No** **: Bowels Yes/No**	**IDC: Yes/No. Type:** **Date Inserted:**	**Skin Integrity/Wounds:** **Pressure Injury Stage:**
Mobility:		**Aids Used:**
Nutritional/Dietary Needs:		
Cognitive Status:	Dementia or Confusion Yes No Does the Patient wander?	
Social & Support History: **Is there any social dynamics that are relevant to the patient's care?**		

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Additional Information:

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