

**REFERRAL TO HOSPICE SOUTHLAND**  
 Email to: [referrals@hospicesouthland.org.nz](mailto:referrals@hospicesouthland.org.nz) or Fax to: 03 211 3082  
 Electronic referrals can also be made online at [www.hospicesouthland.org.nz](http://www.hospicesouthland.org.nz)  
 ALL FIELDS IN **BOLD** MUST BE COMPLETED

<b>PATIENT NAME:</b>	<b>URGENCY: (please tick)</b>		
<b>ADDRESS:</b>	Urgent - within 24-48 hours (weekdays)		
	Non-urgent - within <u>five</u> working days		
<b>ADDRESS ON DISCHARGE:</b> <i>(If different to above)</i>	<b>CONSENT:</b>		
	Patient consents to referral?	Yes	No
<b>PHONE No:</b>	Patient is aware of diagnosis?	Yes	No
<b>NHI No:</b>	Family is aware of referral?	Yes	No
<b>DATE OF BIRTH:</b>	<b>NEXT OF KIN: (if known)</b>		
<b>GP NAME/ADDRESS:</b>	Name:		
	Address:		
<b>GP PHONE No:</b>	Phone No:		
<b>GP is aware of referral?</b>	Yes	No	<b>Relationship to Patient:</b>

<b>DIAGNOSIS:</b>			
Date of Diagnosis:			
<b>RELEVANT MEDICAL HISTORY:</b> <i>(including allergies)</i>			
Resuscitation Status:	NFR	For Resuscitation	Not Discussed
<b>REASON FOR REFERRAL / SPECIALIST PALLIATIVE CARE NEED: (select all appropriate)</b>			
Symptom Management (please specify):			
Psycho Social	Spiritual Support	Care at End Of Life	Support of the Carer
NOTES:			
<b>SERVICES CURRENTLY INVOLVED:</b>			
Medical Specialities:	Oncology	Surgical	Medical Older Persons Health
Other Services:	District Nurse	Cancer Society	Home Help
Other <i>(please specify)</i> :			

<b>PLEASE ATTACH SUPPORTING INFORMATION:</b>	
<ul style="list-style-type: none"> <li>Current medication list, including dose and frequency</li> <li>Relevant radiology reports / blood test results</li> </ul>	<ul style="list-style-type: none"> <li>Documentation confirming diagnosis</li> <li>Recent clinic letters / relevant correspondence</li> </ul>

<b>SIGNATURE:</b>	<b>NAME OF REFERRER:</b>
<b>DESIGNATION:</b>	<b>DATE:</b>
<b>CONTACT PHONE No:</b>	
<b>Palliative Care Nurse Specialist ONLY - Name of initial referrer:</b>	

**THIS REFERRAL CANNOT BE ACTIONED BY OUR TEAM IF:**  
 1. The patient is not aware of the referral  
 2. There is insufficient supporting information

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Hospice Southland  
PO Box 7020  
Invercargill 9814  
**Phone: 03 211 3081**

## **Guidelines for referral to Hospice Southland Palliative Care Services**

Specialist palliative care services at Hospice Southland are coordinated by a multidisciplinary team that works alongside and in partnership with the patient, family and community health providers. Palliative Care embraces the physical, social, emotional and spiritual elements of wellbeing and enhances a person's quality of life.

### **Who can be referred?**

The patient who:

- Has active, progressive, advanced disease for whom prognosis is limited, and the focus of care is quality of life.
- Has an extraordinary level of need and examples of this include:
  - Uncontrolled or complicated symptoms;
  - Specialized nursing requirements relating to mobility, functioning or self-care;
  - Emotional or behavioural difficulties related to the illness, such as uncontrolled anxiety or depression;
  - Concern or distress involving children, family or carers, physical and human environment (including home or hospital), finance, communication or learning disability.
- Agrees to the referral if competent to do so (or an advocate agrees on their behalf).
- Is a resident within Southland and Wakatipu region.

### **Referrals can be made for:**

- Assessment of an individual's palliative care needs
- Symptom assessment, advice and management (outpatient appointment, home visit or inpatient admission)
- Psychosocial and spiritual support
- End of life care and support to patient and family

### **Specialist Palliative Care is largely inappropriate for:**

- Patients with chronic stable disease or disability with a life expectancy of several years.
- Patients with chronic pain problems not associated with progressive terminal disease.
- Competent patients who decline referral. ☒ Patients who are unaware of their underlying disease.
- Those patients whose problems are principally psychological and need specialist psychiatric referral, whether or not they have declined such help.

### **To allow efficient processing of referral, we require (by email or fax):**

- Referral form
- Documentation confirming diagnosis
- Current medication list, including dose and frequency
- Relevant correspondence / radiology reports / blood test results

**PLEASE EXPECT AN ACKNOWLEDGEMENT OF YOUR REFERRAL  
WITHIN 2 BUSINESS DAYS**