HOSPICE CARE ASSOCIATION OF NORTH WEST TASMANIA INC

REFERRAL FORM

CRITERIA FOR REFERRAL

- The Client has a life-limiting illness
- The Client has consented to this referral
- Is the referral urgent? Yes No

Hospice Office Use Only

Client Details:

Surname: _____ Given Name: _____

Address: _____

Suburb: _____ Postcode: 7 __ __ __

Landline: _____ Mobile: _____

D.O.B: _ _ / _ _ /_ _ _ _ Age: _____ Gender: Male / Female / Other

Primary Carer And / Or Person Responsible:

Name: _____ Relationship: _____

Address: _____ Suburb: _____

Postcode: 7 __ __ __ Contact Detail: _____

Reason for Referral:	Respite	☐	Transport	☐	Night-Sits	☐	
Is Client Currently At Home?			Yes	☐	No	☐	
Does The Client Receive In-Home Services?		Yes	☐	No	☐		
Does The Client Use Any Equipment?		Yes	☐	No	☐		
Are There Any Risk Factors In The Home?		Yes	☐	No	☐		

Medical Details:

Diagnosis: _____

Current Issues: _____

_____

Client's GP: _____

Other Comments (If Applicable): _____

_____

Information Taken By / Sent By: _____ Date: _ _ /_ _ /_ _ _ _

Hospice Care Association of North West Tasmania Inc
PO Box 3256, MDC
South Burnie 7320

Phone: 6477 7747
Mobile: 0418 127 590
Email: hospice.burnie@ths.tas.gov.au