Please use ID label or block print

ARMADALE KALAMUNDA GROUP

KALAMUNDA DAY HOSPICE REFERRAL

Family Name:

Given Names

Gender:

UMRN:

DOB:

PATIENT INFORMATION

Patient Details

Name: _____

Date of Birth: _____

Address: _____

_____Postcode: _____

Telephone number:

_____

Current location: ☐ Home ☐ Hospital

☐Care home ☐ Home with Silver Chain

Referrer Details

Name: _____

Position/Relationship to patient: _____

Address: _____

_____Postcode: _____

Contact details: _____

GP Details: _____

_____

Referral date: _____

MOBILITY

☐ Independent

☐ Assist x1

☐ Assist x2

☐ Wheelchair bound

☐ Falls risk

☐ Are there any mobility issues ☐ Yes ☐ No

_____

ADL's

☐ Feed self ☐ Assist _____

☐ Toilet self ☐ Assist _____

Diet type

☐ Normal ☐ Soft ☐ Other _____

Continent ☐ Yes ☐ No

Pad type: _____

Is the Patient aware of referral? ☐ Yes ☐ No

Reason for Referral:

Past Medical History:

Is the patient having any treatment at present ☐ Yes ☐ No (if yes give details)

Current medications:

Is the patient accessing other services/agencies at present ☐ Yes ☐ No (if yes give details)

Please use ID label or block print

ARMADALE KALAMUNDA GROUP **KALAMUNDA** **DAY HOSPICE REFERRAL**	Family Name: Given Names Gender:	UMRN: DOB:

Is there a Goal of Patient Care (GoPC) in Place ☐ Yes ☐ No (attach copy if available)
Has the patient discussed Advance Care Plan ☐ Yes ☐ No (attach copy if available)

NEXT OF KIN DETAILS	**OTHER CONTACT DETAILS**
Name: _____	Name: _____
Address: _____	Address: _____
Contact phone: _____	Contact phone: _____
Mobile: _____	Mobile: _____
Relationship to patient: _____	Relationship to patient: _____

EXCLUSION CRITERIA

If yes to any of the below referral may not be accepted:

☐ Medically unstable
☐ Requires more than one person to assist mobility
☐ Is unable to manage their own medications
☐ Behavioural concerns _____

ADDITIONAL COMMENTS/INFORMATION

Send completed referrals to akg.referrals@health.wa.gov.au