

MEDICAL REPORT FOR PALLIATIVE CARE



TO BE COMPLETED BY MEDICAL OFFICER IN FULL

1. IDENTIFYING PARTICULARS OF PATIENT:

Full name of patient		
Date of birth		
Current Physical address	
Contact numbers	Home:	Cell: <i>(Patient and spouse/family)</i>

2. REASONS FOR REFERRAL

REASON	YES	COMMENTS
PAIN MANAGEMENT		
SYMPTOM MANAGEMENT		
HOME BASED CARE NURSING <i>(Including Care Workers assistance)</i>		
PSYCHOSOCIAL SERVICES		
TERMINAL CARE		
ADMISSION TO IN-PATIENT UNIT / RESPITE		

3. MEDICAL INFORMATION

3.1 PRIMARY DIAGNOSIS:

ICD 10 Code: + Morphology code:

3.2 DATE OF PRIMARY DIAGNOSIS:

METASTASIS	YES	DATE DIAGNOSED	METASTASIS	YES	DATE DIAGNOSED
LIVER			NODES		
LUNG			BRAIN		
BONE			OTHER		

3.3 SECONDARY:

3.4 PROGNOSIS:

3.5. TREATMENT

NATURE	YES	MORE INFORMATION AND DATE COMPLETED
SURGERY		
RADIOTHERAPY		
CHEMOTHERAPY		

3.6. CHRONIC MEDS & ANALGESICS/MEDICATION IN USE (Currently) NB: Attach a copy of prescription of the current medication to the medical report:

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3.7. PAST MEDICAL HISTORY (Relevant to the primary diagnosis - Histology reports and/or test results to be attached):

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4. IS THE PATIENT AWARE OF THE REFERRAL TO HOSPICE?

Yes	No
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5. ARE YOU PREPARED TO SIGN THE DEATH CERTIFICATE OF THIS PATIENT?

Yes	No
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6. REFERRAL/TREATING DOCTOR AND HOSPITAL:

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TEL:

SIGNATURE & QUALIFICATIONS:

DATE:

DOCTOR'S STAMP
