

**Referral Form**

Patient Label

Please discuss this referral with the Hospice RN  
Coordinator / Hospice Doctor (375 4274) before completion

**Diagnosis:**

**Reason for Referral to Hospice: tick boxes as applicable**

End of life care

☐

Symptom management

☐

Complex/Emotional Issues

☐

Describe:

**Significant Family Members/Support People: (Names and any relevant information)**

**Date patient ready for transfer:**

**Discussed with:**

Hospice RN coordinator/Hospice Doctor

☐

Patient and family

☐

General Practitioner

☐

**Name of Referrer:** \_\_\_\_\_

**Designation:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Fax to 375 4267**