# GP/Medical Specialist Referral to Mercy Hospice

**If this referral needs urgent attention (initial contact within 48 hours), please phone the hospice directly (ph 361 5966)**

## MANDATORY

| Patient consents to Hospice Involvement | Patient is New Zealand Resident | | |
|---|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | REQUEST | Community Services ☐ |
| | | PRIORITY | Urgent (<48hr) ☐ |
| | | | Non-Urgent (3-7 days) ☐ |

| | | | |
|---|---|---|---|
| Name | | DOB | |
| Address | | NHI | |
| | | Phone (home) | |
| Ethnicity | | Phone (mobile) | |
| Interpreter required? | ☐ Yes ☐ No | Patient lives alone | ☐ Yes ☐ No |
| Main Carer Name | | Phone (home) | |
| Relationship | | Phone (mobile) | |

| | |
|---|---|
| Diagnosis | |

## Reasons for Referral

| Issues | None | Potential | Significant | Details |
|---|---|---|---|---|
| Physical symptoms | | | | |
| Social needs | | | | |
| Psychological/emotional | | | | |
| Cultural/spiritual | | | | |
| Comments/additional information (incl infection issues eg MRSA/EBSL) | | | | |

| Referrer Name/Address/Phone (or practice stamp) | Signature | Date |
|---|---|---|
| | | |

Fax to 361 5977