HOSPICE IN THE HOME
NIGHT CARER SERVICE
REFERRAL FORM

NHI .....
Patient name: .....
DOB: .....
Address: .....
.....
Tel: .....
Dr:

. Affix patient LABEL if available

Referrer's Name & Signature:	
Service:	
Referrer's Phone number/s:	
Date of Referral:	
Hospice Overnight Care [10pm to 8 am] required in what timeframe:	ASAP ☐ 24 hrs ☐ Other ☐ *(specify)*
Frequency of care requested:	1 night per week ☐ 2 consecutive nights ☐ Other ☐ *(specify)* ....
Patient is aware of this referral:	Y / N *(specify)*

PATIENT CONSENT:

	Yes	No
I have received information about the services offered to me and have had questions answered. I consent to the proposed care, support and risks (if any) as explained.	☐	☐
I understand it is my right to make informed choices and give informed consent. I understand that I am welcome to seek more information at any time.	☐	☐
I understand that my confidentiality is protected by everyone at hospice to comply with the standards in the 'The Code of Health and Disability Services Consumers' Rights'. I give permission for information to be shared between health professionals, such as consultants and specialists, Palliative Care Team and General Practitioner.	☐	☐

Patient Name:		Signature:	
Or Next of Kin:		Signature:	
Date:			

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PATIENT DETAILS:				
Diagnosis / relevant medical history:				
Ethnicity:			NZ Resident:	Y / N
Language spoken at home:			Interpreter Required:	Y / N
Is language / communication assistance required?	Y / N *(specify)*			
Cultural / Spiritual needs *(Iwi, Pacifica, etc)* :				
Living Situation:				
Palliative Care phase:	Deteriorating	*There is gradual worsening of symptoms. There is regular review but no urgent or emergency treatment.*		☐
	End-of-life	*Death is likely in a matter of days. No acute intervention is planned or required.*		☐
	Palliative Performance Scale (PPS):			

ELIGIBILITY CRITERIA:	
☐	Patient has expressed a wish to remain at home for as long as possible, even through to death (verbal or within Advance Care Plan)
AND	
☐	Patient is nearing end-of-life
AND	
☐	Functional ability is ≤ 40% (PPS), but may be changeable
AND ANY OF THE FOLLOWING	
☐	Family / whānau / carers are physically or emotionally unable to continue the caring of their loved one without support
☐	There is limited family support
☐	Carer stress is high.
☐	There are specific cultural / spiritual issues necessitating extra support

CARER / FAMILY DETAILS:			
Marital Status / Family Relationships / Children *(Ages)*:			
Is there a carer?	Y / N	Relationship to patient:	
Name of carer:			
Sex of carer:		Age of carer:	

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Phone *(mobile / landline)*:	
Is carer able to assist with physical care?	Y / N *(details)*

DESCRIPTION OF ASSISTANCE TO BE PROVIDED BY HOSPICE ASSISTANT:		
Manual handling:	Y / N	*(details, Aids, equipment)*
Mobility:	Y / N	Bed bound ☐ Swivel transfer ☐ Walk ☐ *(details)*
Continence management / toileting:	Y / N	*(details, Aids)*
Personal hygiene:	Y / N	*(details)*
Pressure Area care:	Y / N	*(details)*
Other care:	Y / N	*(details)*
Other information relevant to care:		

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HOME ENVIRONMENT CHECKLIST:					
The home environment checklist is to be completed for all referrals to identify key risks.					
Name of person completing check:		Signature:		Date of home environment check:	
Service you work in:	District Nursing ☐ Palliative Care Team ☐ Hospice ☐ Other ☐				
Parking availability at patient's home.	Y / N	*(details)*			
OUTSIDE – gates easy to open. Pathways, steps, verandas are level, non-slip, uncluttered.	Y / N	*(details)*			
OUTSIDE lighting adequate at night.	Y / N	*(details)*			
Pets, dog outside – are they friendly / restrained?	Y / N	*(indicate type of pet, pets name)*			
Location of main entrance door:	Front ☐ Side ☐ Back ☐ *(other details)*				
INSIDE – floor surfaces are level, non-slip, uncluttered. Lighting is adequate for performing work.	Y / N	*(details)*			
INSIDE – adequate warmth for Hospice assistant to work in overnight.	Y / N	*(details)*			
BATHROOM – easy to access for patient. Equipment in place if required e.g. toilet raiser, commode with or without wheels.	Y / N	*(details)*			
BEDROOM – sufficient space around bed, uncluttered floor space.	Y / N	*(details)*			
BEDROOM – bed is at suitable height for working with patient.	Y / N	*(details)*			
Gloves / other protection is available if required.	Y / N	*(details)*			
Carer / family member is aware they have to be present in the house.	Y / N	*(details)*			
Patient is:	Smoker ☐ Non-smoker ☐	*(details)*			
Carer / family members / others smoking in the house?	Y / N *(details)*				
Does the patient show signs / behaviours that indicate resistance to care?	Y / N	*(details)*			

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Is the patient able to accept instructions / cognitively understands?	Y / N	*(details)*		
Is there an identified infection risk?	Y / N	*(details)*		
Is landline telephone available?	Y / N	Is there CELL PHONE coverage?	Y / N	*(details)*
Comments / additional information:				

CHECK LIST COMPLETED BY:	SIGNATURE:	DESIGNATION:	DATE:

FAX TO: Hospice South Canterbury, Senior Registered Nurse 03 6877676

Or EMAIL TO: Hospice South Canterbury nurses@hospicesc.org.nz

OFFICE USE:	
Hospice Care Overnight referral has been accepted:	Y / N
Frequency (e.g. 1 night weekly, 2 nights weekly)	
To commence when:	
Name of Hospice Assistant allocated:	

NAME OF SENIOR HOSPICE RN:	SIGNATURE:	DESIGNATION:	DATE: