IN HOME HOSPICE CARE —— —— REFERRAL FORM

Name of Person Referring: ____

If applicable,
Medical Clinic or Health Unit: ____

Contact number: _________________________________

Date of referral: _________________________________

Client's name	
Date of Birth	❑ Male ❑ Female
Address	
Primary Carer Relationship	
Name of preferred form of contact:	❑ Phone ______________________________ ❑ Mobile ______________________________ ❑ Email ______________________________ ❑ Text/SMS ______________________________
Diagnosis	
Prognosis	
Allergies	
Name of the client's Medical Practitioner Name of Medical Practice	

Will the client need assistance to:		
Get out of bed?	❑ Yes ❑ No	
Walk?	❑ Yes ❑ No	
Carry out daily activities?	❑ Yes ❑ No	
How dependent are they?	❑ Alert and able to assist. ❑ Responsive. ❑ Semi-comatose. ❑ Comatose.	
Are there any mechanical devices e.g., sling hoist, lifting machine, other aid/s used to assist with transfer or walking?	❑ Yes ❑ No	Please list:
Does the client have an advance care plan?	❑ Yes ❑ No	☐ Advance Care Directive ☐ Anticipatory Direction ☐ Medical Power of Attorney ☐ Enduring Power of Guardianship
In the event of a change in condition who should the volunteer call first? (Number in order of preference). In an emergency, volunteers will call 000.	❑ Carer ❑ Palliative Care ❑ Doctor ❑ Ambulance	
Any other services involved in the client's care? ❑ Yes ❑ No	❑ Palliative Care ❑ Home care ❑ Other	Details:
Specific Cultural Needs ❑ Yes ❑ No ____ Behavioural Issues ❑ Yes ❑ No ____		

Authorisation for Release of Information

I, or my Medical Power of Attorney ____________________________________ give permission for my personal and medical information to be shared with Mount Gambier In Home Hospice Care (IHHCare), and for a representative of IHHCare to contact me or my family/carer regarding volunteer assistance and support.

Signed: ____

Please return completed form to email: volunteer@ihhcare.org.au or deliver to 1 James Street, Mount Gambier.