靈實司務道寧養院
Haven of Hope Sister Annie Skau Holistic Care Centre

基督教靈實協會 HAVEN OF HOPE CHRISTIAN SERVICE

STANDARD

REFERRAL FORM

Name of applicant _____ (Chinese) _____ (English) HKID No:_____ Sex/Age:_____ Date of Birth:_____ Telephone:_____(Mobile)_____(Home) (or please attach gum label)	Next of kin Name: _____ Relationship with applicant: _____ Telephone:_____(Mobile)_____(Home) Email address: _____

1.1 Referral for

☐ **Palliative Care (in-patient)** ☐ **Rehabilitation** ☐ **Respite Service**
☐ **Palliative Home Care** ☐ **Long Term Care** ☐ **Out-patient Clinic**

1.2 Patient location:

☐ Hospital / ward / bed no. _____
☐ Home & address_____
☐ OAH (name & address) _____

2.1 Diagnosis:

For Non-Cancer: Please specify: _____
For Cancer: Primary _____ Site of Metastasis: _____

Diagnosis known to patient: ☐Y ☐N Diagnosis known to family: ☐Y ☐N
Patient' consent for referral (Verbal): ☐Y ☐N
Agreed on DNACPR: ☐Y ☐N ☐ Not discussed
Any Infectious Disease: ☐Y, please specify: _____ ☐N

2.2 Medical History + Remarks

_____

_____

▲ Please enclose **discharge summary, medical report, investigation report & other confirming evidence**.

3.1 Present Condition (Please delete as appropriate):

Mental State: Alert / Drowsy / Unconscious / Orientated / Disorientated
Mobility: Independently mobile / Mobile with aid / Wheelchair bound / Bedbound
Feeding: Independent / Dependent / Tube-feeding
Special Care: ☐ Tracheostomy ☐ Central line ☐ Regular blood transfusion ☐ others: _____

3.2 Present Medication & known drug allergy _____

_____

4. Referring Doctor:

Name: _____ Hospital(Ward) / Clinic address: _____
Email address: _____ Tel & Fax No: _____
Signature: _____ Date: _____

5. For internal use:

Date of referral received:_____ Assessment date & staff:_____
Service type: PC/ SCB/ RCS/ HC/ GR/ OR/ QI/ LTC/ RC(D)/ RC(P)

Please fax the completed form and all relevant documents to 2703 5588.

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Conditions NOT suitable for our service:

- Unstable psychiatric conditions including severe depression, unexplained delirium and violent behaviour
- Bleeding or coagulopathy that require frequent transfusion
- Fractures that require special equipment / expertise for treatment
- Special infectious cases, such as VISA, VRSA, VRE, CPE, CRA, MDRA, MRPA, ESBL, Open Tuberculosis, etc.
- Require Dialysis including continuous ambulatory peritoneal dialysis (CAPD) and hemodialysis (HD)
- Require ventilatory support, except nocturnal continuous positive airway pressure (CPAP) ventilation for stable obstructive sleep apnea

Points to note:

- This form is to be filled by the referring doctor and faxed to SASHCC at 2703 5588.
- All referrals will be initially assessed by senior nurse / physician of the centre for admission suitability. The usual response time takes 2-3 working days.
- For enquiry, please call Administration Office at 2703 3000 during office hours.
- For urgent enquiry outside office hours, please call 6971 4510.
- Should there be any dispute, the Centre's decision is final and conclusive.

Centre information:

Address:
Haven of Hope Sister Annie Skau Holistic Care Centre
19-21 Haven of Hope Road, Tseung Kwan O, N.T., HK
Tel: 2703 3000 *Fax:* 2703 5588

Office hours:
Monday to Friday (except public holidays), 9:00am – 1:00pm; 2:00pm – 5:00pm