基督教 靈實協會 HAVEN OF HOPE CHRISTIAN SERVICE

尊重生命 • 改變生命
RESPECTING LIFE • IMPACTING LIFE

CM01

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

REFERRAL FORM

STANDARD

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** ☐ **Infirmary Care** ☐ **Long Term Care**

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: ☐Yes ☐No Diagnosis known to family: ☐Yes ☐No

Patient' consent for referral (Verbal): ☐Yes ☐No

Agreed on DNACPR: ☐Yes ☐No ☐Not discussed

Any Infectious Disease: ☐Yes, please specify: _____ ☐No

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 ☐ 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 / RCS / SCB / PSB / PPB / QI / QIP / RP_O / RP_M / LTC / HC

***Please fax the completed form and all relevant documents to 2785 0721.**

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, PDRA/MDRA, MRPA, Candida auris, 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 2785 0721.
- 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.
- 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

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