

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

1.1 Referral for: In-patient service (Long stay Respite) Palliative home care service
 Palliative care
 Rehabilitation/Convalescent care
 Infirmity 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: PCP / RCS / SCB / PSB / PPB / CCP / GRP / ICP / 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