**PERTUBUHAN HOSPICE NEGERI SEMBILAN**

 No PendaftaranPPM/NS/752

 No. 41, Off Jalan Rasah

 70300 Seremban

 Negeri Sembilan

 Telephone: 06-7621216

 Fax No : 06-7671216

 E-Mail: hospicens2012@yahoo.com

 Website: www.phns.org.my

 **Patient Referral Form (**note: Only referrals from doctors are accepted.)

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Patient’s Name ………………………………………………………. Sex ……………. Age …………...

I.C No. ……………………………………….. Religion ………………. Language spoken ………………….………………

Next of Kin ……………………………………………..…Tel . No.: Hse. ……………………… h/p ………………………

Address : …………………………………………………………

 …………………………………………………………

 …………………………………………………………. Post Code: ……………………..

**History of Illness** (Diagnosis (Disease, Stage, Duration?)

………………………………………………… …. Stage …………………….. Duration ……………….…………

**Treatment (surgery, DXRT, ChemoRx, Dr., Hospital)**

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**Present Problems**

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**Important \*** 1**.** Is the patient informed of the diagnosis? Yes/No ………….

 \* 2. Is the patient informed of the prognosis? Yes/No ………… \* **3. Is the patient/Caregiver agreeable to receiving Hospice Care?** Yes/No …………..

PLEASE PRINT LEGIBLY)

Referring Doctor …………………………………….. Specialty ……………………………………..

Hospital/Clinic ……………………………………………………………………………………………………..

Address …………………………………………………………………………………………………….…..…. …………………………………………………………………………………………………………...

 …………………………………………………………………………………………………..………..

Tel . no. ……………………….. Office ………………………….. Fax ……………………………….………..

 Email Add. ………………………………………..

Doctor’s signature ………………………………….. Date ……………………………..

1. Fax/Call Pertubuhan Hospice Negeri Sembilan.
2. The form is to be given to the patient/caregiver.
3. Please use **black** ink.

For further INFORMATION/HELP please call : Tel 06-7621216 during office hours (9.00am – 4.30pm). (We are an NGO and depend on donations. PLEASE HELP US TO HELP OTHERS !!)

**\* Mandatory.**

**All the above information is mandatory. If omitted, Pertubuhan Hospice Negeri Sembilan has the right to refuse palliative care**