



REFERRAL FORM

1. All boxes must be filled in legibly and accurately.
2. A direct contact number of the referring doctor must be provided.
3. Call our office before referring patients who require terminal discharge.
4. Acceptance of referral will be notified via email / direct contact number.

NAME OF PATIENT:				
NRIC / Passport No:		Nationality:		<input type="checkbox"/> Malaysian <input type="checkbox"/> Other: _____
Hospital RN:		DOB:		Age:
Race:		Religion:		Gender:
Current Address:				Spoken Language:
CONTACT PERSON 1 :			Contact No:	
Relationship:			Spoken Language:	
CONTACT PERSON 2 :			Contact No:	
Relationship:			Spoken Language:	
MAIN DIAGNOSIS: * Please attach Medical Summary and Relevant Reports				
<input type="checkbox"/> Primary Cancer:		Metastases:		
<input type="checkbox"/> End Stage Renal Failure (not on dialysis)				
<input type="checkbox"/> Other:				
Date of Diagnosis:			Prognosis:	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good
Co-morbidities:				
History of Present Illness:				
Surgical History:				
Radiotherapy:				
Chemotherapy:				
Discharge Medications:				
REFERRING DOCTOR Name & MMC No / Signature & Stamp			Hospital:	
			Department:	
Direct Contact No:			Referral Date:	
Is patient informed of:		Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		Prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is family informed of:		Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		Prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient admitted at point of referral?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Referral to hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No

Information to give to patient and family:

1. Hospice staff will contact patient or family within two (2) working days of receiving referral.
2. In the home setting, urinary catheters and nasogastric tubes are changed on a monthly basis.
3. Equipment will only be provided to patients under Kasih medical services.

No. 16, Jalan SS 3/29, 47300 Petaling Jaya, Selangor
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