HOSPICE PALLIATIVE CARE SERVICE PROVIDERS
COMMON REFERRAL FORM

Please select **one** preferred Care Type and corresponding Service Provider.

CARE TYPE:

☐ **HOME CARE**
- ☐ Assisi Hospice
- ☐ Buddhist Compassion Relief Tzu Chi Foundation (Singapore)
- ☐ Dover Park Hospice*
- ☐ HCA Hospice Care
- ☐ Metta Hospice Care**
- ☐ MWS Home Hospice
- ☐ Singapore Cancer Society
- ☐ Star PALS***
- ☐ Tsao Foundation

Is this a 'terminal' discharge? Yes / No

☐ **INPATIENT CARE**
- ☐ Assisi Hospice
- ☐ Bright Vision Hospital
- ☐ Dover Park Hospice
- ☐ St Andrew's Community Hospital
- ☐ St Joseph's Home
- ☐ St Luke's Hospital

☐ **DAY CARE**
- ☐ Assisi Hospice
- ☐ Dover Park Hospice*
- ☐ HCA Hospice Care

To enquire for more details/service:
* Central area (Tan Tock Seng Hospital referrals) only.
** Home care service covers parts of East or North East Singapore only.
*** For all referrals to Star PALS, clinicians to complete an additional document attached (PaPaS) for eligibility assessment mandated by MOH.

PATIENT DETAILS (Block letters please. Do not use patient's sticker.)

Full Name: ______________________________

______________________ **Race:** ______________

NRIC: ______________ **Citizenship:** ______________

Date of Birth: __________ **Dialect Group:** ______________
DD / MM / YYYY

Age: _____ **Sex:** M / F **Religion:** ______________

Marital Status: Married / Single / Widowed / Separated / Divorced

Occupation: ______________________________
Past/Present

Address: ______________________________

______________________ **Postal Code:** ________

Tel: ______________ **Language(s) spoken:** ______________

Present Location: Home / Hospital ______________
Name of Hospital

Ward Tel: ______________ **Ward/Bed:** ______________

Expected date of discharge: ______________

KEY FAMILY CONTACT OR MAIN CAREGIVER AT HOME
(If main caregiver is a domestic helper, please indicate the best person to contact.)

Full Name: ______________ **Relationship:** ______________ **Language(s):** ______________

Contact No: Home ______________ **Office** ______________ **Mobile Phone** ______________

REFERRAL DETAILS (Please use block letters and full names. Do not use initials.)

Referring Consultant/Registrar/GP: ______________ **Hospital/Dept:** ______________

Other Consultants involved: ______________ **Patient/Family informed of referral:** Yes / No

Primary Diagnosis: ______________ **Histopathological Diagnosis:** Yes / No

Sites of Metastases: ______________ **Date of Diagnosis:** __________(MM/YYYY)

Prognosis: 0-6 days / 1-7 wks / 2-3 mths / 4-6 mths / 7-12mths / >12mths **Present Condition:** Stable / Deteriorating

Is a MSW involved? Yes / No **Name of MSW** ______________ **Hospital Palliative Care team involved?** Yes / No

Is patient currently under a hospice service? Yes / No **Name of Service:** ______________

Reason(s) for referral: ☐ Pain & symptom control ☐ Psychosocial support ☐ Shared ☐ Terminal care
☐ Drug titration (specify): ______________ ☐ others (specify): ______________

Has patient been informed of diagnosis: Yes / No
Has patient been informed of prognosis: Yes / No
Has family been informed of diagnosis: Yes / No
Has family been informed of prognosis: Yes / No

Name of Patient: ______________________________

SUMMARY OF MEDICAL HISTORY (Please include relevant investigations e.g. CT / MR I / bone scan)

CURRENT PROBLEMS

1) 4)

2) 5)

3) 6)

CURRENT FUNCTIONAL STATUS

Mental status: Alert / Drowsy / Comatose / Orientated / Confused / Demented

Mobility: Independent / Ambulant with supervision / Ambulant with support / Chair-bound / Bed-bound

Feeding: Independent / Needs supervision / Partially dependent / Totally dependent

☐ Feeding tube (Ryle's/Freka/PEG) ☐ Intranasal O_2 (____L/min) ☐ Cope loop (Site:_______) ☐ PCN: RT / LT / Bilateral
☐ Tracheostomy ☐ Colostomy / Ileostomy ☐ Urinary catheter ☐ Others________________________________

CURRENT MEDICATIONS *DRUG ALLERGY:* No / Yes ______________________________
Please specify

Name of Drug/Dose/Frequency	Reason Prescribed	Name of Drug/Dose/Frequency	Reason Prescribed
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

SOCIAL BACKGROUND (Please attach Social Report and Means Test if available.)

Family Tree: (Indicate decision maker &/or main carer if known.)

Patient's concerns:

Family's concerns:

Name of doctor completing this form: ____________________________ **Date:** ____/_____/________
DD MM YYYY

Signature:____ **Mobile Phone:** ______________________

Please **Fax** this form to the selected Service Provider.

Assisi Hospice	Fax: 6253 5312	Tel: 6832 2650
Bright Vision Hospital	Fax: 6881 3872	Tel: 6248 5755
Buddhist Compassion Relief Tzu Chi Foundation (Singapore)	Fax: 6262 6443	Tel: 6570 2330
Dover Park Hospice	Fax: 6258 9007	Tel: 6500 7272
HCA Hospice Care/ Star PALS	Fax: 6291 1076	Tel: 6251 2561
Metta Hospice Care	Fax: 6787 7542	Tel: 6580 4695
MWS Home Hospice	Fax: 6435 0274	Tel: 6435 0270
Singapore Cancer Society	Fax: 6221 9575	Tel: 6421 5832
St Andrew's Community Hospital	Fax: 6586 8004	Tel: 6586 8000
St Joseph's Home	Fax: 6252 3227	Tel: 6268 0482
St Luke's Hospital	Fax: 6561 3625	Tel: 6895 3216
Tsao Foundation	Fax: 6593 9522	Tel: 6593 9500

Paediatric Palliative Screening Scale (PaPaS)

Name of Patient : ____________________

Please read each item and check the option that best describes the patient and their family. Every item should be answered, unless a selected option from the previous item instructs to skip it.

	Domain 1: Trajectory of disease and impact on daily activities of the child		
1.1.1	With reference to the past 3 months, the disease trajectory of the child, in comparison with the child's own baseline, is…	…Stable	0 ☐
		…Stable, but slowly deteriorating	1 ☐
		…Unstable with slow deterioration	2 ☐
		…Unstable with significant deterioration (Please skip 1.1.2)	4 ☐
1.1.2	With reference to the past 3 months, the impact of condition on daily activities of the child, in comparison with the child's own baseline.	No impact	0 ☐
		Daily activities are impacted/restricted	1 ☐
		Daily activities are severely impacted/restricted	2 ☐
1.2	In the past 6 months, there was a more than 50% increase in unplanned hospital admissions *(compared to previous periods)*	No	0 ☐
		Yes	3 ☐
	Domain 2: Expected outcome of treatment directed at the disease and burden of treatment		
2.1	Treatment directed at the disease, even if not administered… (does not include treatment of disease-related complications, such as pain, dyspnea or fatigue)	…is curative.	0 ☐
		…controls disease and prolongs life with good quality of life.	1 ☐
		…does not cure or control but has a positive effect on quality of life.	2 ☐
		…does not control and has no effect on quality of life.	4 ☐
2.2	Burden of treatment, including both disease-directed and symptom-directed treatments. (consider frequency and skills involved; e.g. side effects, hospital stay, additional tasks for patients/caregivers)	No/minimal burden OR no treatment is planned	0 ☐
		Low level of burden (e.g. simple oral medication or diet modification)	1 ☐
		Medium level of burden (e.g. feeding tubes, catheters, medications with adverse effects)	2 ☐
		High level of burden (e.g. hospitalization, tracheostomy, BiPAP/C-PAP, PICC line, frequent suctioning)	4 ☐

**This form is a required appendix for referrals to Star PALS; please fax this form together with the SHC Common Referral Form.*

Paediatric Palliative Screening Scale (PaPaS)

Domain 3: Symptom and problem burden				
3.1.1	Symptom intensity over the past 3 months (consider unplanned hospitalization or outpatient visits, symptom crises)	Patient is asymptomatic (Please skip 3.1.2)	0	☐
		Symptom(s) are mild	1	☐
		Symptom(s) are moderate	2	☐
		Symptom(s) are severe (Please skip 3.1.2)	4	☐
3.1.2	Difficulty of symptom control over the past 3 months (consider unplanned hospitalization or outpatient visits, symptom crises)	Symptom(s) are easy to control	0	☐
		Symptom(s) are controllable	1	☐
		Symptom(s) are difficult to control	2	☐
3.2	Psychological distress of patient related to symptoms	Absent	0	☐
		Mild	1	☐
		Moderate	2	☐
		Significant	4	☐
3.3	Psychological distress of parents or family related to symptoms and suffering of the child	Absent	0	☐
		Mild	1	☐
		Moderate	2	☐
		Significant	4	☐
Domain 4: Preferences of Health Professional				
4.1	Patient/parents wish to receive palliative care or formulate needs that are best met by palliative care.	No	0	☐
		Yes (Please skip 4.2)	4	☐
4.2	You or your team feel that the patient would benefit from palliative care.	No	0	☐
		Yes	4	☐
Domain 5: Estimated Life Expectancy				
5.1	Estimated life expectancy/Prognosis	Several years	0	☐
		1 – 2 years	1	☐
		3 months to a year (Please skip 5.2)	3	☐
		Less than 3 months (Please skip 5.2)	4	☐
5.2	Would you be surprised if this child died in 6 months' time?	Yes	0	☐
		No	2	☐

Please fill the details below.

Name of Doctor completing this form : ______________________ Date : ____________________

Signature : ______________________ Contact No. : ____________________

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