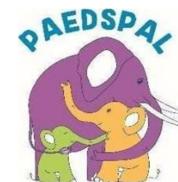
PATIENT REFERRAL FORM - GROOTE SCHUUR HOSPITAL ADOLESCENT PATIENTS

This is a detailed referral form to ensure best shared care and smooth communication.



Email: referrals@paedspal.orq.za Contact number: 021 2005873

URGENT IMPORTANT NON-URGENT

Date of Referral:		
PATIENT INFORMATION		
Hospital folder number:	Date of birth:	
Full name and surname:	Child's race:	Gender:
Address:		
Primary Caregiver's name:	Contact numbers (Please supply 2 or more contacts details)	
SUB SPECIALIST DOCTOR INFORMATION		
Name:	Email:	
Mobile number:	Ward number and contact details:	
Department:	Clinic number:	
DETAILS OF FOLLOW UP		
Date:	Contact person or Phone number:	
Clinic:	Department:	
Planned place of care for acute medical care:		
COLLECTION OF MEDICATION		
Place:	Prescribing team or person:	
DIAGNOSES AND COMPLICATIONS	**PSYCHOSOCIAL DETAILS (FAMILY COMPOSITION)**	
Stage:	Family insight and expectations:	
Prognosis: (days/weeks/months/years):	Adolescent's insight and expectations:	
Treatment intent:	CDG application completed: Yes No RFAD application: Yes No	
CHECKLIST WITH REFERRAL: Family have been told about the referral Recent Discharge Summary Included CDG completed Pathway of care is clear to the family if there are unmanaged symptoms. Clear plan about follow up for symptom reviews and medication at their local healthcare facility.	**DOCUMENTED RESUSCITATION PLAN CPR OR (ALLOW NATURAL) DEATH:** Yes No **LETTER GIVEN IN THE EVENT OF A DEATH AT HOME:** Yes No	
INTERVENTIONS REQUESTED: Symptom Management Psychosocial support Bereavement Support Advance Care Plan Family Meeting Ethics review Case Discussion Creative Arts Therapy	**SPECIFIC CONCERNS:**	
For Paedspal administrative purposes. Outcome of Referral:		