PATIENT REFERRAL FORM

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

Paedspal only uses the personal information you provide us with for purposes relating to our NGO operations, and to comply with our obligations towards you as a beneficiary of our services in keeping with the Protection of Personal Information Act, 4 of 2013 ("POPIA").

☐ URGENT ☐ NON-URGENT

DATE OF REFERRAL:		**DATE OF ADMISSION:**	
REFERRING DOCTOR:		**REFERRING HOSPITAL:**	
DOCTOR'S MOBILE NO.:		**REFERRING DEPARTMENT/SPECIALITY:**	
DOCTOR'S EMAIL:		**WARD:**	
TYPE OF REFERRAL:	**IN-PATIENT** ☐	**OUTPATIENT** ☐	

PATIENT INFORMATION		
HOSPITAL NUMBER:	**DATE OF BIRTH:**	
SURNAME:	**CHILD'S RACE:**	**GENDER:**
FIRST NAME:	**LANGUAGE OF COMFORT:**	
ADDRESS:		
PRIMARY CAREGIVER'S NAME:	**CONTACT NUMBER:**	
RELATIONSHIP TO PATIENT:	**ALT CONTACT NUMBER:**	

REASON FOR REFERRAL (please tick)

☐ **Symptom management**	☐ **Case Discussion**	☐ **Ethical dilemma**	☐ **Supportive medical counselling**	☐ **Psychosocial support**	☐ **Bereavement support**

DIAGNOSES AND COMPLICATIONS:	**PALLIATIVE CARE CONCERNS TO BE DISCUSSED:**
LIMITATIONS INTERVENTIONS: E.g. ICU/ventilator/inotropes	**RESUSCITATION STATUS:**

STAGE OF DISEASE (please tick): Early ☐ Middle ☐ Advanced ☐ Pre-terminal ☐ Unsure ☐

CURRENT ANALGESIA AND LEVEL OF CONTROL:	**MEDICATION LIST:**
SYMPTOM REVIEW: tick if present Pain: ☐ Scale used: Score: ☐	FLACC ☐ FACES ☐ NIPS ☐ ELAND ☐
CHILD'S UNDERSTANDING OF ILLNESS:	**PARENT/CAREGIVER'S UNDERSTANDING OF ILLNESS:**