(223675-X)

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off Jalan Sekuci,
Taman Sri Bahtera
Jalan Cheras,
56100 Kuala Lumpur.
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E-mail: info@hospismalaysia.org
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HOSPIS MALAYSIA
PATIENT REFERRAL FORM

NOTE: ***Only referrals from DOCTORS will be accepted as this service works best as a complement to medical care.***
PLEASE **USE BLACK INK** TO COMPLETE THIS FORM.

Patient's Name: ____IC No.: ________________________________

Reg. No.:________________________ Home Phone:___________________________ Sex:_______ Age:_________

Address:____

____

Next of Kin:____ Religion:________________________________

Languages Spoken: ____ ______

History / Diagnosis & Present Problems: ____

____

____

____

Treatment / Medication: ____

____

____

Prognosis:

Has the patient been informed of the diagnosis? Yes / No Date of Diagnosis ____________________

Has the patient been informed of the prognosis? Yes / No

Referring Doctor:____ Speciality: ______________________________

Specialist Consultant:____

Hospital / Name of Clinic: ____

Address: ____

____

Office Phone No.:__________________________________ Fax. No.:____

Referring Doctor's Signature: ___________________________________Date: ______________________________

TO CONTACT HOSPIS MALAYSIA

1. Call Hospis Malaysia at 03-9133 3936 or, fax to 03-91333941
2. The form may either be given to the patient, or kept at the Ward if the patient is still in hospital
3. We discourage mailing the form to us as this could cause considerable delay in attending to the patient's assessment
4. If further information or clarification is required, please call us.

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