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Hobart TAS 7000
Phone: (03) 6231 9249
Web: www.hospicevolunteers.org.au

HOSPICE VOLUNTEERS REFERRAL: CONFIDENTIAL
This form is to be used to request a community (in home) volunteer.
RETURN TO:
supportofficer2@hospicevolunteers.org.au

Are there any COVID-19-related issues that apply to this referral? If so, please phone us to discuss.

- Please print clearly if handwriting your referral.
- Please phone us to discuss your referral and to ensure we have received it.
- Where possible please keep us informed of:
 - client hospital admissions
 - changes to client circumstances which may affect volunteer
 - client death

DATE OF REFERRAL:

Urgent referral? Yes No

Client consent obtained for referral: Yes (required)

CLIENT DETAILS: *PLACE ID STICKER IN BOX BELOW OR INSERT INFORMATION.*

Client / patient name:
Client ID #:
DOB:
Address:
.....
Phone number(s):

PRIMARY CARER DETAILS:

Primary carer's name/ relationship to patient

.....

Address:

Phone number(s):

Palliative Care Level of client and diagnosis information, where relevant for Hospice Volunteers to understand the client needs, *and relevant comorbidity/s*:

REASON/S FOR REFERRAL (CLIENT/CARER NEEDS): PLEASE NOTE RELEVANT CARE INFORMATION *eg carer respite, mobility requirements/aids, O2 canister, seeking companionship/ outings for coffee etc.*

SUPPORTS IN PLACE/OTHER REFERRALS *eg domestic/shopping assistance, social/community services supports, THS SPCS etc:*

CLINICIAN CONTACTS:

G.P:

PHONE: _____

SPECIALIST CLINICIAN:

PHONE: _____

COMMUNITY NURSE:

PHONE: _____

REFERRED TO HOSPICE BY:

POSITION/SERVICE:

PHONE:

SIGNATURE: _____

Please tick if you would like to be kept informed of our progress in supporting this client.

Yes / No

Thank you for your referral to Hospice Volunteers.

PLEASE EMAIL TO: supportofficer2@hospicevolunteers.org.au