



# Pertubuhan Hospis Klang

**Hospice Klang** 82, Jalan Sri Sarawak 4, Taman Sri Andalas,  
41200 Klang

Tel: 33242125. 33244740 Fax: 33243125

Website: [www.hospiceklang.org](http://www.hospiceklang.org)

## Patient Referral Form (note: only referrals from doctors are accepted)

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
IC No: \_\_\_\_\_ Religion \_\_\_\_\_ language spoken \_\_\_\_\_  
Next Kin \_\_\_\_\_ Tel No. \_\_\_\_\_  
Address \_\_\_\_\_ Pos code \_\_\_\_\_

### History of Illness

**Diagnosis** (Disease, Stage, Duration?)

\_\_\_\_\_ Stage \_\_\_\_\_ Duration \_\_\_\_\_

**Treatment**

**Surgery** \_\_\_\_\_

**Chemotherapy** \_\_\_\_\_

**Radiotherapy** \_\_\_\_\_

**Others** \_\_\_\_\_

<b><u>Important</u></b>	<b>Present Problems</b> _____			
<b><u>Important</u></b>	<b>Is Patient informed of the diagnosis?</b>	<input type="checkbox"/> Yes/No	<b>Is Patient informed of the prognosis?</b>	<input type="checkbox"/> Yes/No
	<b>Is Patient informed of Referral to Hospice Klang?</b>	<input type="checkbox"/> Yes/No		

Referring Doctor \_\_\_\_\_ Speciality \_\_\_\_\_  
Hospital / Clinic \_\_\_\_\_  
Address \_\_\_\_\_  
tel: \_\_\_\_\_ fax: \_\_\_\_\_  
Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

1. Fax / Call Hospice Klang
2. Please give filled form to Patient (\*to be submitted to Hospice Klang)
3. Please use black ink

For further Information/Help, Call Hospice Klang Tel: 33242125