Pertubuhan Hospis Klang / Hospice Klang ***(www.hospiceklang.org)***

PT140457, Persiaran Delima / KS 09
Kota Bayu Emas, 41200 Klang

Tel: 33184774, 012-6223073
Fax: 33194664

Patient Referral Form (**only referrals from doctors are accepted)

Patient's Name _____ Sex _____ Age _____

IC No: _____ Religion _____ language spoken _____

Next Kin _____ Tel No. _____

Address _____ Pos code _____

Important

1. Fax Referral to Centre or Submit by person to Centre

2. Please give a Copy of referral to patient (*FAX may not be clear)

3. Patient needs to contact Hospice Klang to arrange for 1st visit

4. Do NOT use Email or WhatsApp (Fax:33194664 Tel:33184774, 012-6223073)

History of Illness

Diagnosis (Disease,Stage,Duration?)

Stage	*Duration*

Treatment **Surgery, Chemotherapy, Radiotherapy, Current Treatments

_____

_____

_____

_____

_____

Important

Present Problems: _____

_____

_____

_____

Is the patient informed of the diagnosis? YES / NO ☐

Is the patient informed of the prognosis? YES / NO ☐

Is the patient informed of referral to Hospice Klang? YES / NO ☐

Important
Please fill YES or NO

Referring Doctor _____ **Speciality**

Hospital / Clinic _____

Address _____

_____ tel: _____ fax: _____

Doctor's Signature _____ **Date:** _____

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Date: _____

Patient Name: _____

Cancer - Primary & Spread (Metastasis)

Cancer (Primary): _____

When Diagnosed / Duration: _____

Spread (Metastases):
Please Tick YES or NO (*or Don't Know)

	Yes	No	Don't Know
Brain			
Lungs (R) or (L)			
Liver			
Ribs: which? _____			
Spine (Neck, Thorax, Lumbosacral?) _____			
Other Bones: which? _____			
Peritoneum			
Lymph Nodes: which? _____			
Other Organs/Regions: which? _____			

Other Information:

_____