



**Pertubuhan Hospis Klang / Hospice Klang** ([www.hospiceklang.org](http://www.hospiceklang.org))

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

Tel: 33184774, 012-6223073

Fax: 33194664

Email: [hpkgrefer@gmail.com](mailto:hpkgrefer@gmail.com)

**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 / Email 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 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:

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Date: \_\_\_\_\_

**From: HOSPICE KLANG TEL: 03 33184774, 012-6223073 FAX: 03 33194664  
Email: hpkgrefer@gmail.com**

To: \_\_\_\_\_

## **Re: Hospice Klang - REFERRAL**

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### **REMINDER / REQUEST:**

- 1. Please use our latest referral form**  
(\*see Attached page or download from website,- [www.hospiceklang.org](http://www.hospiceklang.org))
- 2. Filled in requested information in the form (\*all available)**
- 3. The referral can be faxed/email to our centre or passed to the patient to submit by hand. (\*Do NOT sent by SMS or WhatsApp)**
- 4. A copy of referral must be given to the patient to pass to our Office**  
(\*Fax/email copies often blurred)
- 5. If a referral is by fax/email, it is expected that patient(\*or carer) must call our center to confirm referral and consent to referral**
- 6. Remind the patient (& carer) of the need to call our centre:**
  - ) to confirm referral is received,
  - ) to confirm consent for our services
  - ) to confirm admission
  - ) to initiate home care visits

### **Important**

- ) **We DO NOT call patients after receiving referral**
- ) **Patients need to call FIRST. We wait for their calls**
- ) **This instruction is clearly stated in our referral form**

**Thank you for your cooperation.**

**Hospice Klang**