

HOME VISIT

Hospice Referral Form (Penang)

Tick the chosen provider, and send the completed form to the chosen provider.

(Service provision varies among providers; Referrers should check with respective providers if unfamiliar)

☐ **Penang Hospice Society**
(covers the state of Penang)

250-A, Jalan Air Itam, 10460 Pulau Pinang.

Tel (general inquiries): 04-2284140/04-2294140

HP for referrals: 016-2244140 Email: info@penanghospice.org.my

☐ **Palliative Unit, Pusat Perubatan USM Bertam**
(covers Penang, southern Kedah)

Institut Perubatan dan Pergigian Termaju, Universiti Sains Malaysia, 13200

Kepala Batas, Pulau Pinang.

Tel : 04-5622201/2203 HP: 012-347 6773 Email: paliatifppt@usm.my

☐ **Charis Hospice**

(covers Penang Island only)

26 & 28, Lintang Paya Terubong 3, 11060 Ayer Itam

Tel : 04-827 9668, HP: 011-1246 6757

Email : charishospice@gmail.com

☐ **Tzu Chi Foundation**

(Spiritual and psychological support; covers the state of Penang)

316, Jalan McCalister, 10450 Pulau Pinang

Tel: 04-2281013. Email: wooigeap@hotmail.com

Patient data and contact details

Name: _____ IC: _____

Patient contact number: _____ Age: _____ Marital status: _____ Gender: M / F

Person to contact: _____ Relationship to patient: _____

Person to contact: _____ Relationship to patient: _____

Address where the patient is going to stay: _____

Address and
contact details
should be
checked with
the person
before referral

Clinical information

Diagnosis, problems (symptoms, psycho-social-spiritual): _____

Reason for referral: _____

Comorbidities: _____

Latest lab (please attach imaging with referral form): _____

Medications: _____

What has been discussed? : _____

Has the following been discussed Patient Family

Diagnosis ☐ ☐

Severity ☐ ☐

Prognosis ☐ ☐

Disease treatment options ☐ ☐

Advance care plan/preparations ☐ ☐

Patient currently at Hospital Ward _____ / Nursing home _____ / Clinic / Home.

Advise patient/family to call hospice on arrival at home.

Referrer source information

Name, title: _____ Follow-up date (if applicable): _____

Unit/Department/Center: _____ Contact details: _____

Signature: _____ Date: _____

INPATIENT

Hospice/Palliative Referral Form (Penang)

Tick the chosen provider, and send the completed form to the chosen provider.

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☐ **Pure Lotus Hospice of Compassion**

Stay-in hospice

73, Jalan Utama 10460, Pulau Pinang

Tel: 04-229 5481, HP: 011-5509 5481 Email: lyanshih@gmail.com

☐ **Palliative Unit, Pusat Perubatan USM Bertam
(covers Penang, southern Kedah)**

Clinics, inpatient, and home visit service

Institut Perubatan dan Pergigian Termaju, Universiti Sains Malaysia, 13200
Kepala Batas, Pulau Pinang.

Tel : 04-5622201/2203 HP: 012-347 6773 Email: paliatifippt@usm.my

☐ **Palliative Unit, Hospital Pulau Pinang /
Hospital Bukit Mertajam**

Clinics, inpatient, and consult service

Out-of-hospital Referrals: clinician to connect with Palliative
Physician via hospital operator

Private Hospitals

☐ **Mount Miriam Cancer Hospital**

Private clinics and inpatient service; hospice beds available

Email: palliativecare@mountmiriam.com

Tel: 04-8923808 HP: 0165217044

Patient data and contact details

Name: _____ IC: _____

Patient contact number: _____ Age: _____ Marital status: _____ Gender: M / F

Person to contact: _____ Relationship to patient: _____

Person to contact: _____ Relationship to patient: _____

Address where the patient is going to stay: _____

Address and contact details should be checked with the person before referral

Clinical information

Diagnosis, problems (symptoms, psycho-social-spiritual): _____

Reason for referral: _____

Comorbidities: _____

Latest lab (please attach imaging with referral form): _____

Medications: _____

What has been discussed? : _____

Has the following been discussed	Patient	Family
Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
Severity	<input type="checkbox"/>	<input type="checkbox"/>
Prognosis	<input type="checkbox"/>	<input type="checkbox"/>
Disease treatment options	<input type="checkbox"/>	<input type="checkbox"/>
Advance care plan/preparations	<input type="checkbox"/>	<input type="checkbox"/>

Referrer source information

Name, title: _____ Follow-up date (if applicable): _____

Unit/Department/Center: _____ Contact details: _____

Signature: _____ Date: _____