



THE TYGERBERG HOSPICE TRUST

NPO No: 005/336NPO | PBO No: 930000611 | Practice No. 7900287 | Reg. No: IT5297/97 | VAT No: 4560272132

CONFIDENTIAL REFERRAL BY PATIENT

A. PATIENTS PERSONAL INFORMATION

| | | | |
|-------------------|-------|-----------------|-------|
| Name: | _____ | Surname: | _____ |
| Address: | _____ | | |
| ID No: | _____ | DOB: | _____ |
| Tel: | _____ | Cell: | _____ |
| Marital Status: | _____ | | |
| Religion: | _____ | | |
| Home Language: | _____ | | |
| Hospital Name: | _____ | Hospital No: | _____ |
| Medical Aid Name: | _____ | Medical Aid No: | _____ |
| Medical Plan: | _____ | | |
| Pharmacy Name: | _____ | Tel: | _____ |
| | | Fax: | _____ |

B. RESPONSIBLE RELATIVE / FRIEND

| | | | |
|------------------|-------|----------------|-------|
| Name: | _____ | Surname: | _____ |
| Identity Number: | _____ | Date of Birth: | _____ |
| Relationship: | _____ | | |
| Address: | _____ | | |
| Tel: | _____ | Cell: | _____ |
| | | E-mail: | _____ |



B. RESPONSIBLE RELATIVE / FRIEND (Continued)

Reason for Referral?

Pain Control

Symptom Control

Emotional Support

Respite

Other

C. PREVIOUS SUPPORT

Name of Social Worker / Therapist: _____ Organisation: _____

Support given:

Counselling of Patient Counselling Family including Minor Grant Other

Church: _____

Is any other organisation involved at present: Yes No

If **Yes**, please supply the name of the organisation/s: _____

CONSENT AND INDEMNITY

The patient and family members hereby give permission for the staff and trained volunteers of Tygerberg Hospice to do home visits, provide care and give advice on alternative sources of care.

AND

The members, office bearers, employees and volunteers of The Tygerberg Hospice Trust in whole or in part, shall not be liable in any way whatsoever for any loss, injury or damage of whatsoever nature and whether or not caused by negligence (gross or otherwise) of the members, office bearers, employees or volunteers of The Tygerberg Hospice Trust.

AND

The clause above will be binding on the heirs, dependents, executors, trustees or any other legal representative of the patient.

Patient / Family / Significant Other
Print Name

Signature

Witness

Signature

Witness

Signature

Signed at _____ on the _____ day of _____ 20 _____