Counselling referral for family members of person under another hospice

Please print all information clearly and accurately

Title		**Family Name**					
Given Names			**Preferred Name**				
NHI Number			**DOB**		**AGE**		
Address							
Suburb/ City				**Post Code**			
Home Phone		**Mobile No**					
Email		**Ethnicity**					
Iwi		**Religion/Spirituality**					
Country of Birth		**Language Spoken**					
GP Name **GP Practice**		**GP Phone No** **GP Email**					

PATIENT INFORMATION:

Title		**Family Name**	
First Name		**Relationship to person referred**	
Date of Birth			
Date of Death		**Place of Death**	
Under hospice care?	**(Please circle)** Yes No	**If yes, name of hospice**	

REFERRAL DETAILS:

Reason for referral			
Client consent to referral	**(Please circle)** Yes No	**GP aware of referral**	**(Please circle)** Yes No
Name of referrer & job designation			
Contact phone no.		**Email**	

Other relevant information	

Form completed by	**(Please print name & sign)**
Date	