PHYSICIAN REFERRAL FORM FOR
THE LIVHEALTH CHARITABLE FOUNDATION

NAME:____ DOB: / / AGE: _______

ADDRESS: ____ GENDER: ☐ MALE / ☐ FEMALE

CURRENT LOCATION: ☐ HOME/ ☐ HOSPITAL/ ☐ OTHER

MAIN CARE-GIVER/NEXT OF KIN:

NAME:________________________________ RELATIONSHIP:________________________________

ADDRESS:____________________________ PHONE NUMBER:_____________________________

DIAGNOSIS & CURRENT CONDITION

MAIN DIAGNOSIS:	DIAGNOSIS BASED ON HISTOLOGY/RADIOLOGY/CLINICAL FINDINGS DETAILS:
SITE OF METASTASES:	OTHER DIAGNOSES:
CURRENT CONDITION: STABLE/IMPROVING/DETERIORATING • ABLE TO TOLERATE ORAL FEEDS YES/NO • NGT/PEG FOR FEEDING YES/NO • URINARY CATHETER YES/NO • OXYGEN DEPENDENT YES/NO Level of O2 required___________	
CURRENT MEDICATIONS:	
SOCIAL Hx	

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REASON FOR HOME REFERRAL (Please place an "x" & give details)

	x	Please specify specific patient needs
HOME COMPREHENSIVE PALLIATIVE MEDICINE MANAGEMENT *Incorporates, medical, emotional, spiritual, social domains with main focus on quality of life. Prognosis >6months*		
SYMPTOM MANAGEMENT *eg: Uncontrolled nausea, vomiting, pain, shortness of breath, constipation, depression, anxiety.*		
END-OF-LIFE CARE *Poor performance status and estimated prognosis of <6 months*		
MULTIDISCIPLINARY SUPPORT *Home physical therapy, home counseling, home wound care, art therapy, grief counseling, short-term respite caregiving services - max 5 days, home occupational therapy*		
OTHER		

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ECOG PERFORMANCE STATUS (Please place an "x")

1	Ambulatory & able to carry out light work	
2	Ambulatory & capable of all self-care but unable to carry out work activities. Up and about more than 50% waking hours	
3	Capable of only limited self-care, confined to bed/chair more than 50% waking hours	
4	Completely disabled, cannot carry out any self-care	

PROGNOSIS (Please tick): ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

Please indicate the urgency of this assessment (Please place an "x")

☐ EMERGENCY (needs to be seen within 24hours)
☐ URGENT (needs to be seen within 1 week)
☐ NON-URGENT (within 2-4weeks)

Name of Referring Doctor____

Signature______________________________ Contact Number:________________________________

LIVHEALTH PHYSICIAN Dr. ________________________ has reviewed Referring Doctors Form by Date: ________________________ and has made the decision below, regarding whether the above patient if applicable for The LivHealth Charitable Foundation Funding Approval.

Indicate below if the patient was approved/ not approved and why:

o Approved *(please state below specific medical needs for funding, eg: home doctors visits, specific equipment rental and duration, subject to re-evaluation.)*

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o Not Approved. Reason____