DOCTOR'S REFERRAL FORM

TO : MEDICAL DIRECTOR/PALLIATIVE CARE NURSE
PERAK PALLIATIVE CARE SOCIETY
NO. 47, JALAN SULTAN AZLAN SHAH
31400 IPOH, PERAK D.R.
TEL: 05-5464732 / 017-5532489
EMAIL: admin@ppcs.org.my

FROM: _____
ADDRESS: _____
_____
_____
_____
TEL NO : _____

1. PATIENT'S PARTICULARS

Full Name: _____ NRIC No: _____ Sex: _____

Date of birth: _____ Age: _____ Marital Status: _____

Address: _____

_____Post Code: _____ Tel: _____

Full Name of Next of Kin: _____

Relationship: _____ Tel: _____

2. MEDICAL REPORT (FOR DOCTOR'S ATTENTION)

Date of Diagnosis: _____ Site of Primary: _____ Stage: _____

Site of Secondaries: _____

Treatment received: _____

_____

Follow up required at hospital? Yes/ No: _____

	Diagnosis	**Prognosis**
Family is aware of	Yes/ No	Yes/ No
Patient is aware of	Yes/ No	Yes/ No

Patient's present condition: Stable ☐ Deteriorating ☐

Needs pain control ☐ Not in pain ☐

Other remarks: _____

Present Medication: _____

_____

_____

_____

Date: _____ Doctor's Signature & Chop: _____

NB.: Please give this letter to patient and advise patient or family member to call PPCS, Tel: 05-5464732 if they wish to be under the care of PPCS.

FORM: HCP4

Location Map