



Medical Report — Non-Malignant Illness

To be completed by the patient's medical practitioner

PATIENT DETAILS

Date	Patient's name(s)	Patient's surname	Title	Age
Address				
Cell number		Next of kin and cell number		
Reason for referral to HospiceWits Palliative and Hospice Care (please circle)				
Respite Symptom Control Terminal Care Counselling				

CLINICAL INFORMATION

What illness is the patient suffering from?

Duration of illness

Severity

Co-morbidities (please specify as clearly as possible)

Has the patient undergone any surgery? If yes, please specify nature, findings and dates

Name of surgeon

Current medication — name, dose, frequency and route

Any other doctors who need to be informed

Who supplies the patient's medication? (please circle)

State

Hospital

Private

What is the life expectancy of the patient? (please circle)

Days

Weeks

Months

Years

**ASSESSMENT**

Mobility	Bed Bound Requires Assistance Wheelchair Ambulant
Feeding	Unable to Swallow N/G or PEG Feeding Soft Diet Fluid Diet Normal Diet
Continence	Incontinent Continent Catheter Nappies
Level of consciousness	Alert Semi-Comatose Unconscious Confused

SYMPTOMS (PLEASE CIRCLE)

Pain	Mild Moderate Severe
Dyspnoea	Mild Moderate Severe
Oxygen requirements	None Intermittent Continuous
Cachexia	Mild Moderate Severe
Pressure sores	Skin Intact Superficial Deep

Is the patient aware of the diagnosis?	Yes No
Do we have your permission to assess the patient?	Yes No

Very important: please include copies of any relevant reports, including pathology, radiography and histology.

The HospiceWits team comprises doctors, palliative care registered nurses, social workers and volunteers.

REFERRING PRACTITIONER

Initials and surname	Signature	Specialty
Postal address	Practice number	
Physical address		
Landline	Cell number	Email

Please return the completed report to intake@hospicewits.co.za, or call 011 483 9100.