Hospice East Rand
Care at home.

Hospice East Rand
Practice No: 7900066
218 Kemston Ave, Benoni, 1501
Email: intake@hospiceeastrand.co.za

CONFIDENTIAL MEDICAL REPORT TO BE COMPLETED BY DOCTOR

Patient Name:	Patient Age:
Patient Address:	Patient Contact Number:
	ICD10 Code:
Postal Code:	**Morphology Code**:

Primary Diagnoisis:

Complications:

Co-Morbidities:

Reason For Referral:

If diagnosed with a life limiting illness (eg.CCF), is it classified as “end stage”?	YES	NO

General condition of the patient (e.g. bedridden, frail):

ECOG Score:	

Sites of Metastases (if applicable):

Treatment & Date

Surgical Procedure:							Date:
Radiation	YES	NO	Date:	Chemotherapy	YES	NO	Date:

Medication & Dosage (Please itemize all)

1.	3.
2.	4.

Does the patient have an drug idiosyncrasies?

Has the patient recently been tested for Covid-19?	YES	NO	Date Tested:	Result:

Has the patient been in isolation for any reason?

What is the estimated expectation of life?		Days		Weeks		Months		Years

Has the patient been informed about his/her diagnosis?	YES	NO
Do you agree to sign the Death Certificate when patient dies?	YES	NO
Do you agree to sign the Cremation B Form when patient dies?	YES	NO
Do we have your permission for any member of the Hospice team to visit this patient?	YES	NO

The team comprises a nurse, doctor, social worker and trained volunteer caregiver.

Name of Doctor Applying (block capitals please):

Address:

Contact Number:	Email Address:

DOCTOR’S STAMP

Signature of Doctor Applying

Date