GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

APPLICATION FORM
PALLIATIVE CARE PROGRAMME

Please complete this application if your patient requires to be enrolled on the palliative care programme.

TO BE COMPLETED BY REFERRING DOCTOR

MEMBER DETAILS:

Membership number

ID number

Title Initials

Surname

Email address

Telephone (H) (W)

(Cell phone)

PATIENT DETAILS:

Name and surname

Title ID number or date of birth

Address

Code

Email address

Current location Home Hospital Hospice Care facility

NEXT OF KIN DETAILS:

Name and surname

Relationship to patient Telephone

DOCTOR DETAILS:

Surname

Initials

Practice number

Provider discipline

Email address

Telephone Fax

Cell phone

TO BE COMPLETED BY REFERRING DOCTOR (CONTINUED)

Give a brief history of the patient's current illness and treatment:

Please indicate with an "X" in the box below which concerns require specialist palliative care input.

	MAIN REASON FOR REFERRAL
	Advanced care planning
	Carer support
	End-of-life care
	Medical and allied medical needs
	Psychological support and counselling
	Respite for family support
	Social assessment
	Other

	SERVICE REQUESTED
	Home assessment
	Hospice admission
	Care at home
	Other

	STAGE OF DISEASE
	Advanced
	Pre-terminal
	Unsure

Has any advanced care planning discussions with the original treating doctor, the patient or family members taken place? If yes, please state below:

Should you have any further queries regarding the programme, please call the Fund's integrated care department and ask for the palliative care specialist to discuss the patient's condition. A referral letter must also be submitted to palliativecare@momentum.co.za.

Referring doctor's signature

D	D	M	M	Y	Y	Y	Y

Date

11/19

CONTACT DETAILS Parc du Cap, 7 Mispel Road, Bellville 7530
TEL 0861 888 109 **EMAIL** palliativecare@momentum.co.za **WEBSITE** www.goldenarrowmed.co.za