



**ST LUKE'S  
HOSPICE**

St Luke's Hospice  
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## APPLICATION FORM – Part 2

to be completed by doctor

DATE
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### CONFIDENTIAL MEDICAL REFERRAL

NAME OF PATIENT						
FOLDER NUMBER				RT NO		
Diagnosis				ICD 10	Morphology code	
Site of primary disease				Date of initial diagnosis		
Secondary deposits	Liver	Y	N	Brain	Y	N
	Lung	Y	N	Nodes	Y	N
	Bone	Y	N	Other	Y	N
Sites of bone metastases						
Other sites/ complications						
MEDICAL HISTORY Past & present Co-morbidities	Specify					

### TREATMENT TO DATE

Surgery / procedures	Curative	Date	Details			
	Palliative	Date				
Radiotherapy	Curative	Date	Sites			
	Palliative	Date				
	ONGOING	Y				
Chemotherapy	Curative	Date completed				
	Palliative	Date completed				
	ONGOING	Y	N			
Hormones				Continuation essential	Y	N
MEDICAL / OTHER						
Future treatment planned						
Will you continue to see the patient?	Regular visits			Only if required		

### PRESENT CLINICAL CONDITION

Preterminal	Y	N	Unconscious	Y	N	Confusion	Y	N	
Pain	Nil	Mild	Severe	Sites					
Vomiting	Y	N	Incontinence	Bladder		Bowel			
WOUNDS / BEDSORES	Y	N	Specify						
Psychiatric illness				Dementia					
Other									
PERFORMANCE STATUS – Please tick box				Category 0 = NORMAL			3 = IN BED > 50% OF TIME		
				1 = SYMPTOM AMBULATORY			4 = BED BOUND		
				2 = IN BED < 50% OF TIME					
ALLERGIES									

