

**HOSPIS KANAK-KANAK MALAYSIA (MALAYSIAN CHILDREN'S HOSPICE)**

D-2-11, PUSAT KOMERSIAL JALAN KUCHING,
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REFERRAL FORM: MALAYSIAN CHILDREN'S HOSPICE (HOSPIS KANAK-KANAK MALAYSIA)

Patient's Name: _____ Age: _____

NRIC: _____ Hospital RN: _____ Gender: _____ Weight: _____

Race: _____ Religion: _____ Preferred Language: _____

Address (current): _____

Contact Person & Phone No.1: _____ Relationship: _____

Contact Person & Phone No.2: _____ Relationship: _____

FAMILY BACKGROUND**Family Income**

Father I.C & Occupation: _____

☐ < RM4,850

Mother I.C & Occupation: _____

☐ RM4,851 – RM10,960

Total of Sibling: _____

☐ > RM10,960

Medical History

Latest Diagnosis & Date of Diagnosis:

Present Problems:

Recent Investigation Results:

Treatment Plan:

Current Medications:

Reason for Referral	<ul style="list-style-type: none">• Pain and Symptom Control• Transition of Care	<ul style="list-style-type: none">• Psychosocial Support• End of Life Care
Symptom care plan Given to patient	<ul style="list-style-type: none">• Yes• No	
Advance Care Plan Direction	<div>1.During Cardiopulmonary Arrest</div> <div>2.Preferred End-of life care</div> <div>3.Maximum place of care during hospital admission</div>	<ul style="list-style-type: none">• Active Resuscitation• Not for Resuscitation• Hospital• Home• ICU / HDU• Ward

Referring Doctor (Name & Signature/ Stamp)

Contact No. / Email (For case update/direct correspondence:

Referring Unit/Department:

Hospital/Clinic:

Other Specialist Involved:

Date Referral: