hospicemalta

care | compassion | dignity

REFERRAL FORM (C 001.1)

Hospice Malta offers Palliative Care to the patient and support to the family and works together with existing Health & Social Services.

Name of Patient _____ I.D. No. _____

Date of Birth _____ Tel . No. _____

Address _____

Diagnosis _____

Is the patient aware of Diagnosis? ☐ Yes ☐ No ☐ Don't know

Reason for referral _____

Present Problems _____

Present location of Patient _____

I, the Patient, hereby give my consent to Hospice Malta to process and record personal data in order to be provided full care as needed. I am fully aware that should I wish I can request (in writing) to access my data and amend. I can also request (in writing) or for my data to be removed at any time.

Patient's Signature _____

I, the Doctor, hereby confirm that it is not in the Patient's best interest to know he/she is receiving Hospice Care.

Doctor's Signature _____

Family Doctor _____ Tel. No. _____ Mob. No. _____

Family Doctor's email address _____

Consultant _____

Referring Doctor _____ Tel. No. _____ Mob No. _____

Date _____ Referring Doctor's Signature _____

Next of Kin _____ I.D. No _____ Relation _____

Address _____

Telephone Number _____ Mobile _____

I, next of kin, hereby give my consent to Hospice Malta to process and record my personal Data. I am fully aware that I can access my data at any time. I am fully aware that should I wish I can request (in writing) for my data to be removed at any time.

Next of Kin Signature _____

* *In compliance with the Data Protection Act XXVI of 2001*

Hospice Malta,
39, Good Shepherd Avenue,
Balzan BZN1623, Malta

Tel: (+356) 21 440 085
Fax: (+356) 21 484 769

Email: info@hospicemalta.org
Website: www.hospicemalta.org
VO/0062

Formola ta' Kunsens

(Consent Form C 004.2)

Jiena hawn taħt iffirmat, _____, bil-karta tal-Identita numru _____, qiegħed nagħti l-kunsens lill-Hospice Malta biex f'każ li nkun rikoverat fl-isptar Mater Dei, l-amministrazzjoni tal-isptar tgħaddi l-informazzjoni segwenti (sala fejn nkun rikoverat u jekk ġejtx rilaxxat) lill-Hospice Malta. Għaldaqstant, qiegħed nawtoriżża wkoll lill-membri tal-Hospice biex jagħtu ismi u l-karta tal-identita tiegħi lill-amministrazzjoni tal-isptar. Jien infurmat li din l-informazzjoni dwari tiġi pproċessata skond l-Att dwar il-Protezzjoni u il-Privatezza tad-Data (Kap. 440).

F'każ li ma nkunx nixtieq nibqa nagħmel użu mis-servizzi ta' Hospice Malta nirriserva d-dritt li nirtira dan il-kunsens skond il-liġi. Nirriserva wkoll id-dritt biex nitlob aċċess, nemenda, u fejn japplika nħassar informazzjoni personali, billi nagħmel rikjesta bil-miktub lil Hospice Malta.

I, the undersigned _____, ID card number _____, am hereby giving my consent so that in the eventuality of my admission to Mater Dei Hospital, information regarding my admission and discharge as well as the ward I am admitted to, can be divulged to Hospice Malta. I am also giving my consent to Hospice Malta to forward my name and ID card number to Mater Dei Hospital Administration. I am informed that such data about me is processed in accordance with the Data Protection Act (Cap 440).

In the event that I do not wish to use the services of Hospice Malta any longer, I may revoke this consent according to law. I may also exercise my right to request access, rectification and where applicable the erasure of personal data, by submitting a written request to Hospice Malta.

_____ _____

Firma/Signature Data/Date