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*

Formola ta Kunsens
(Consent Form C 004.2)

Jiena hawn taht iffirmat, _______________, bil-karta tal-Identita numru _______________, qieghed naghti il-kunsens lill-Hospice Malta biex f'kaz li nkun rikoverat fl-isptar Mater Dei, l-amministrazzjoni tal-isptar tghaddi l-informazzjoni segwenti (sala fejn nkun rikoverat u jekk gejtx rilaxxat) lill-Hospice Malta. Ghaldaqstant, qieghed nawtorizza wkoll lill-membri tal-Hospice biex jaghtu ismi u l-karta tal-identita tieghi lill-amministrazjoni tal-isptar. Jien infurmat li din l-informazzjoni dwari tigi pprocessata skont l-Att dwar il-Protezzjoni u il-Privatezza tad-Data (Kap. 586).

F'kaz li ma nkunx nixtieq nibqa naghmel uzu mis-servizzi ta Hospice Malta, nirriserva d-dritt li nirtira da nil-kunsens skond il-ligi. Nirriserva wkoll id-dritt biex nitlob access, nemenda, u fejn japplika inhassar informazzjoni personali, billi naghmel 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 586).

In the event that I do not wish to use the services of Hospice Malta any longer, I may revoke the 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