FAH067033

Austin HEALTH

REFERRAL TO PALLIATIVE CARE

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ……..……

AFFIX PATIENT LABEL HERE

REFERRAL TO PALLIATIVE CARE

Date of referral: ___/___/___

Referral from:	☐Austin ☐Northern Health ☐RMH ☐Peter Mac ☐Werribee Mercy ☐Eastern Palliative Care ☐Banksia Palliative Care ☐Mercy Palliative Care ☐Melbourne City Mission Palliative Care ☐Other _____	**Referral to:**	☐Austin ☐Northern Health ☐RMH ☐Peter Mac ☐Werribee Mercy ☐Eastern Palliative Care ☐Banksia Palliative Care ☐Mercy Palliative Care ☐Melbourne City Mission Palliative Care ☐Other _____
Service requested	☐Inpatient PC Unit ☐Inpatient PC Unit Back Up Bed ☐Pall Care Outpatient Clinic (For Consult Service referral please use Cerner) ☐Symptom Management ☐Respite ☐EOLC ☐Other	**Priority**	☐Non urgent ☐Semi urgent *(can wait 1 week)* ☐URGENT *(within 2 days - ring service to discuss)*
Specific reason for referral			

Referrer's Details	**Surname:**	**First Name:**
	Department:	**Contact number:**
	Role:	**Email:**

Patient Details	**Phone/Mobile:**	**Email:**	
	Indigenous: ☐No ☐Aboriginal ☐TS Islander	**Country of birth:**	**Preferred language:**
Clinical Information supporting referral	**Primary diagnosis:**		
	Current treatments: ☐Oxygen ☐Syringe Driver ☐IDC ☐Ext. Drains ☐Wound ☐PPM/AICD	**Recent history and current clinical status:**	

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	Planned treatments/Treatment regimens:		**Expected care needs:**	
	Phase of Care: ☐Stable ☐Unstable ☐Deteriorating ☐Terminal		**Karnovsky: _____** **RUG Score: _____**	
	Physical Symptom Issues: ☐Pain ☐Dyspnoea ☐Nausea ☐Vomiting ☐Constipation ☐Diarrhoea ☐Tiredness ☐Appetite ☐Other		**Psychological Symptom Issues:** ☐Anxiety ☐Depression ☐Confusion ☐Restlessness ☐Existential distress ☐Other	
	Family/Caregiver Issues: ☐Distress ☐Anxiety ☐Exhaustion ☐Sickness ☐Unable to meet care needs ☐No Carer ☐Complex needs			
Care arrangements	**Understanding of disease and prognosis, ACP if in place:**			
	Living arrangements: ☐Lives alone ☐Lives with family/other		**Goals of care (including personal and social goals), preference for site of death:**	
Primary Carer / NOK	**First Name and Surname:**		**Relationship:**	**Phone:**
Describe risks	**Environmental:**	**Physical:**	**Psychosocial:**	**Other:**
Other relevant information	**Documents attached** ☐Discharge Summary ☐Pathology / Radiology Reports ☐Anticipatory Medication Orders ☐Current medication list ☐Care Plan ☐Recent and relevant notes ☐Other _____		**Equipment needs:** ☐Equipment not required ☐Equipment ordered – Date for delivery: ___/___/___ ☐Equipment ordered and in place	
OFFICE USE ONLY				
Referral Outcome	**Referral Accepted:** ☐YES ☐NO		**Date referrer notified of outcome:** ___/___/___	