

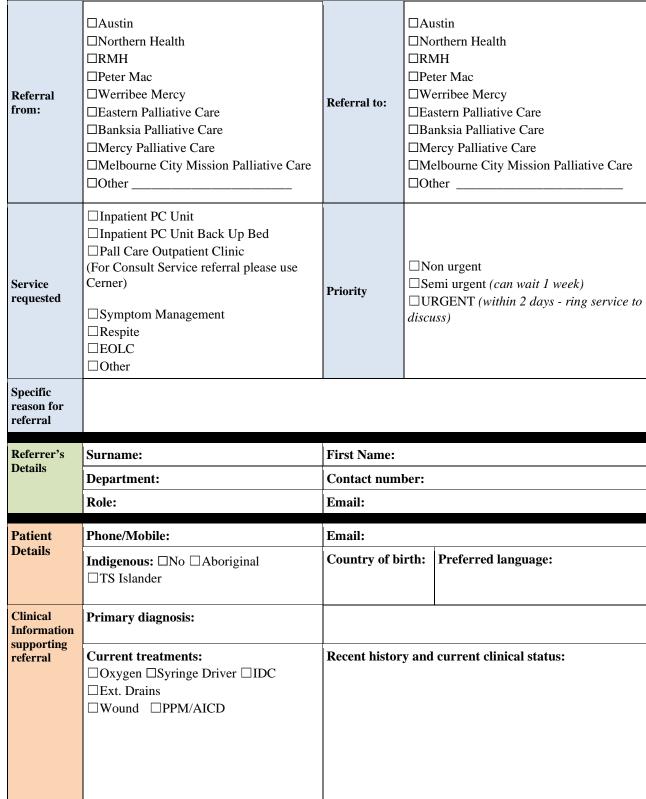
U.R Number
Surname
Given Name(s)
Date of Birth

REFERRAL TO PALLIATIVE CARE

Date of referral: ___/__/

AFFIX PATIENT LABEL HERE

REFERRAL TO PALLIATIVE CARE



REFERRAL TO PALLIATIVE CARE





U.R Number
Surname
Given Name(s)
Date of Birth

REFERRAL TO PALLIATIVE CARE			AFFIX PATIENT LABEL HERE		
	Planned treatments/Treatment regimens: Phase of Care: Stable Unstable Deteriorating Terminal Physical Symptom Issues: Pain Dyspnoea Nausea Vomiting Constipation Diarrhoea Tiredness Appetite		Expected care needs: Karnovsky: RUG Score: 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 dis				
	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 U	SE ONLY				
Referral Outcome	Referral Accepted: □YES □NO		Date referrer notified of outcome://		