



# Palliative Care Services Referral Form

TITLE	FAMILY NAME	MRN		
GIVEN NAMES		VMO		
ADDRESS		DOB	SEX	
		ADMISSION DATE		

## Specialist Palliative Care Services Referral Form for Services In Northern Sydney

### Facsimile Transmission

#### Upper North Shore (Roseville to Hawkesbury River)

- Neringah Hospital PCU Tel: 9488 2200 Fax: 9488 2247
- Community Multidisciplinary Palliative Care Service Tel: 9488 2200 Fax: 9488 2247
- Day Hospital at Neringah Tel: 9488 2200 Fax: 9488 2247
- Outpatient Clinic at Neringah Hospital Tel: 9488 2200 Fax: 9488 2247
- Public Hospital consults at Hornsby Hospital - please contact the Community Team and fax a hospital consult form to them

#### Northern Beaches (Manly/Warringah and Pittwater)

- Community Multidisciplinary Palliative Care Service Tel: 9998 0800 Fax: 9979 7221
- Day Hospital at Mona Vale Tel: 9998 0800 Fax: 9979 7221
- Outpatient Clinic at Mona Vale Hospital Tel: 9998 0800 Fax: 9979 7221
- Public Hospital consults in Manly and Mona Vale Hospitals - please contact the Community Team and fax a hospital consult form to them

#### Lower North Shore (Spit Bridge, to Chatswood to Ryde)

- Greenwich Hospital PCU Tel: 9903 8227 Fax: 9903 8100
- Community Multidisciplinary Palliative Care Service Tel: 9903 8211 Fax: 9903 8265
- Day Hospital at Greenwich Hospital Tel: 9903 8211 Fax: 9903 8265
- Outpatient Clinic at Greenwich Hospital Tel: 9903 8211 Fax: 9903 8265
- Public Hospital consults in Ryde Hospital - please contact the Community Team and fax a hospital consult form to them

For referrals for **Private Hospitals consults**, please contact the local community palliative care service as per the numbers above.

**From:** \_\_\_\_\_

**Contact details:** \_\_\_\_\_  
*(we will contact you via these details to confirm arrangements)*

**Date:** \_\_\_\_\_ **No. of following pages:** \_\_\_\_\_

When returning referral, please include:

- **Written referral letter from the patients GP or specialist**
- **GP computer history printout**
- **Patient's medical discharge summary**
- **Recent investigations and relevant test results**
- **Current medications**
- **Specialist correspondence**

When faxing this form, please note the following - in accordance with NSW Department of Health Information Privacy Code of Practice, identifying data should only appear on the *Personal Information* page. Patient's date of birth (DOB) should appear on following sheets as a means of identification

To make an appointment for a pre-admission visit by the patient or carer to the Palliative Care Unit, contact the Nursing Unit Manager of After Hours Supervisor.

Palliative Care Services Referral Form

CRTRIAL

## Palliative Care Services Referral Form

TITLE	FAMILY NAME	MRN		
GIVEN NAMES		VMO		
ADDRESS		DOB	SEX	
		ADMISSION DATE		

Healthcare cover:	
Medicare No:	
DVA card colour:	DVA No:
Private fund:	Fund No:
<b>Current location of patient:</b> Home <input type="checkbox"/> Hostel <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> other <input type="checkbox"/> (state): _____	

FAMILY/CARERS/LMO		
Name #1:	LMO	
Relationship:	Address:	
Address:		
Tel: (H)	Tel:	
(B)	Community Nurses: Y / N    Private:    Y / N	
(M)	Location:	
Name #2:	Tel:	
Relationship:	Other services:	
Address:	Marital status:	Lives alone Y / N
Tel: (H)	Cultural background:	
(B)	Preferred language:	
(M)	Interpreter:            Y / N	
<i>Please asterisk emergency contact *</i>	Religion:	Chaplain    Y / N

Other Specialists:		
1.	2.	3.
Tel:	Tel:	Tel:
Address:	Address:	Address

If requesting admission to a Palliative Care Unit, please answer the Principles of Admissions to a Palliative Care Unit (*please tick*)  yes  no

- The patient and family understand and accept that cardio-pulmonary resuscitation is not usually offered in palliative care units. Admissions may be inappropriate if CPR is requested  yes  no
- The patient and family understand and accept that long-term care is not offered. All patients are continuously reviewed as to the appropriateness of their ongoing stay.  yes  no
- The patient and family understand and accept that patients who are stable and not requiring specialist palliative management will have a discharge plan formulated which may include home or another facility such as a nursing home.  yes  no

## Palliative Care Services Referral Form

TITLE	FAMILY NAME	MRN		
GIVEN NAMES		VMO		
ADDRESS		DOB	SEX	
		ADMISSION DATE		

Reason for Referral	Needs Review by	Infection Control
<input type="checkbox"/> Symptom control	<input type="checkbox"/> Physio <input type="checkbox"/> Nursing	MRSA <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Assessment and review	<input type="checkbox"/> OT <input type="checkbox"/> Social Work	VRE <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Terminal care	<input type="checkbox"/> D T <input type="checkbox"/> Pastoral Care	
<input type="checkbox"/> Other ( <i>detail</i> )	<input type="checkbox"/> Medical	
	<input type="checkbox"/> Other ( <i>whom</i> )	

DETAILS OF DIAGNOSIS	
<b>Diagnosis:</b> <b>Known metastases if cancer:</b> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Brain <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Lymph Nodes <input type="checkbox"/> Other <input type="checkbox"/>	<b>Date of diagnosis:</b> <b>Method of diagnosis:</b>
<b>Past Medical History</b>	<b>PREVIOUS TREATMENT</b>
	<b>Surgery:</b>
	<b>Date:</b> <span style="float: right;"><b>Surgeon:</b></span>
	<b>Hospital:</b>
	<b>Radiotherapy</b> ( <i>date, sites</i> ) <span style="float: right;"><b>Radiation Oncologist:</b></span>
	<b>Hospital:</b>
	<b>Chemotherapy</b> ( <i>date, drug regimen</i> ) <span style="float: right;"><b>Oncologist:</b></span>
	<b>Hospital:</b>
	<b>Functional Status</b>
	<b>Prognosis:</b>
	<b>Functional status:</b> independent <input type="checkbox"/> Partial assist <input type="checkbox"/> Full Assist <input type="checkbox"/>
	Falls <input type="checkbox"/> Wanders <input type="checkbox"/> Aggressive <input type="checkbox"/>
	Walking <input type="checkbox"/> Frame <input type="checkbox"/> Stick <input type="checkbox"/> Wheelchair <input type="checkbox"/>
<b>Psychiatric history:</b>	<b>Diet:</b>
	Special needs:
	<b>Current Issues</b>
<b>Current behavioural problems:</b>	
<b>Smoker: Y / N Pack years:</b>	
<b>Asbestos exposure: Y / N</b>	
<b>Alcohol: nil/drinks per week:</b>	
<b>Illicit Drugs:</b>	
<b>ALLERGIES</b>	

CURRENT MEDICATIONS (include dose, frequency, route of administration)		

Referred by					
Name of Doctor/Nurse	Doctor/Nurse Signature	Designation	Tel. No:	Ext/Page No:	Date

