SESLHD GUIDELINE COVER SHEET

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AUTHORS	Dr Elaine Gallagher Linda Magann CNC Dr Jan Maree Davis Margaret O'Connor CNE Dr Lisa Potter Linda.magann@health.nsw.gov.au
POSITION RESPONSIBLE FOR DOCUMENT	SESLHD Nurse Manager Cancer and Palliative Care Stream
FUNCTIONAL GROUP(S)	Cancer and Palliative Care Services
KEY TERMS	Palliative Care
SUMMARY	This document describes the referral criteria for staff to understand when a referral to obtain palliative care advice and support is appropriate.

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Referral to Palliative Care

Appendices

Appendix 1 St George Hospital, The Sutherland Hospital Referral for Specialist Palliative Care Medical Consultation Form
Appendix 2 Calvary Community Palliative Care Team referral form
Appendix 3 Calvary Health Care Kogarah Residential Aged Care Palliative Care Referral Form
Appendix 4 Admission and Discharge Criteria Community Palliative Care Team CHCK
Appendix 5 Prince of Wales Hospital Internal Palliative Care Referral Form
Appendix 6 Sacred Heart Health Service Community Supportive and Palliative Care Referral Form

Section 1 – Background

To achieve safe and high quality Palliative Care including end of life care, systems and processes to support clinicians need to be in place.

Health service organisations with a specialist Palliative Care service need to develop formal referral guidelines and processes so staff understand when to access advice from a Specialist Palliative Care clinician[2].

This guideline aims to provide information for staff on:

1. Palliative Care definitions
2. Responsibilities of staff
3. The referral criteria to obtain Palliative Care advice and support
4. Inpatient and Outpatient referral processes
5. Documentation requirements

Section 2 - Definitions

- **Palliative Care**:
  - Palliative Care is more than only end-of-life care and physical symptom management. Palliative Care helps people live their lives to the fullest when living with a life-limiting or terminal illness. It is person-centred care that considers the individual's physical, emotional, social and spiritual needs, as well as the needs of their loved ones and carers. It also empowers patients and their loved ones to make decisions about their future care through Advance Care Planning.

- **Palliative Care Providers:**
  - All clinical staff are responsible for providing clinical management and care coordination using a palliative approach for the person with uncomplicated needs associated with a life limiting illness and/or end of life care.
  - Specialist Palliative Care offers support for patients with complex Palliative Care needs. 'Complex needs' are those physical, psychosocial or spiritual needs that are not responding to the basic palliative approach. Patients and/or families may have needs across multiple domains. Needs are patient-centred, not diagnosis dependent.

- **Palliative Care Services:**
  - **Inpatient**
    i. Palliative Care Unit: Inpatient Palliative Care Units (sometimes called 'hospices') are designed to support Palliative Care patients with complex needs once care at home is no longer possible. Patients are admitted under a Specialist Palliative Care doctor and receive care from a multidisciplinary team for their physical and psychosocial/spiritual wellbeing.
    ii. Consultative: Patients admitted under non-Palliative Care teams in an acute hospital can receive Specialist Palliative Care support and advice

from Palliative Care Consultative Teams. These patients are often receiving contemporaneous treatments from their primary care teams.

- **Outpatient**
  i. Clinic: Ambulatory patients with complex Palliative Care needs can be seen in outpatient clinics by a Palliative Care Specialist doctor or nurse.
  ii. Community: Patients at home who require the support of the Palliative multidisciplinary team (MDT) or who are unable to attend an outpatient clinic can receive Palliative Care support at home or in their Residential Aged Care Facility (RACF).

Section 3 - Responsibilities

Nursing and Allied Health:

Nursing and allied health staff can identify patients who are appropriate for referral to the specialist Palliative Care service. They work as part of a multidisciplinary approach to improve outcomes for patients with life limiting illness.

Medical team:

The treating medical team is responsible for the identification of patients appropriate for involvement of Palliative Care. The team should provide basic management of common symptoms and collaborate with Specialist Palliative Care services when basic management is insufficient. The team should initiate patient-centred discussions about future care planning including provision of prognostic information and the role of Palliative Care.

Section 4 - Criteria for Referral:

- The patient has progressive life limiting or life threatening disease (malignant and/or non-malignant)

  and one or more of the additional criteria below:

- The patient has complex symptoms that require specialist assessment/management
- The patient and/or family has complex emotional, social or spiritual needs that require specialist assessment
- The primary care team and/or patient and family would benefit from support when planning for, or undertaking withdrawal of life prolonging treatment
- It would not be a surprise if the patient died in the next 12 months and support is needed for advance care planning discussions
- The patient is dying and the primary care team requires additional support and /or advice.

In cases where the patient meets the above criteria for referral they may also be appropriate for review in order to:

- Facilitate a link to the local Community Palliative Care Team (CPCT) **or**
- Discuss appropriateness of transfer to a Palliative Care inpatient Unit.

Section 5 - The Referral Process

Information to be included by the referrer:

- The patient and their family/care giver is aware of the referral
- The palliative diagnosis
- Current treatment and future treatment planned
- Other relevant diagnoses and criteria for referral
- Other relevant pathology and imaging results if not available on eMR
- Names of relevant specialists and GP
- Patient/family or carer request
- If appropriate, expected prognosis and current Advance Care Plan/Advance Care Directive

How to make a referral:

St George Hospital (SGH), The Sutherland Hospital (TSH), Calvary Hospital (CHCK)

- For urgent Palliative Care advice for any patient **after hours**, please contact the Palliative Care Consultant on call via switch at Calvary Health Care Kogarah (CHCK) 95533111

Consultative Patient Service:

- The SGH and TSH Palliative Care Teams are consultative services that do not admit patients directly
- Referrals are taken from any member of the MDT and from patients and their families/ carers
- Referrals are made via the paging system or via email to any member of the Palliative Care team (nursing or medical).

Inpatient Palliative Care Unit:

- The local inpatient Palliative Care unit for St George and Sutherland Shire patients is CHCK.
- Transfer to an inpatient Palliative Care unit is arranged via the Palliative Care Consult Team at SGH/TSH, via the local Calvary Health Care Community Palliative Care Team (CPCT) or by submitting a referral directly to the IPU for an inter-hospital transfer after discussion with a Palliative Specialist

Outpatient Palliative Care Clinics:

- Oncology patients may be referred to Palliative Care Clinics based in the Cancer Care Centre at SGH/TSH/ CHCK or St George Private Hospital
- Referrals can be made through the Cancer Care receptionists using the Referral for Specialist Palliative Care Medical Consultation Form – see Appendix 1

Other Out-patient clinics for Palliative Care patients with non-malignant diagnoses include:

- Cardiology Supportive Clinic at SGH
- Hepatology Supportive Clinic at SGH
- Renal Supportive Clinic at SGH and TSH
- Respiratory Supportive Clinic at TSH
- MND Specialist Clinic at CHCK

Referrals can be made through each hospital department's respective outpatient clinics or please contact the CNC for each site for assistance.

Community Palliative Care Team (CPCT)

- The MDT from Calvary Health Care visits patients who reside in the South Cooks River, Bayside & Georges River LGAs.
- Patients can be referred to the CPCT from their GP, specialist, and primary care team in hospital or via referrals from the consultative team using the CPCT referral form-see Appendix 2**.** The completed referral form can be emailed to SESLHD-Calvary-CPCT@health.nsw.gov.au or faxed to (02) 9588 1635. Ensure all relevant information, recent specialist correspondence, pathology, radiology and medication lists are included.
- Use the Calvary Health Care Kogarah Residential Aged Care: Palliative Care Referral Form to consult in a local RACF see Appendix 3.
- For more detailed information regarding the roles and responsibilities within the team, and shared care models review the Calvary Health Care Kogarah Admission and Discharge Criteria Community Palliative Care team (CPCT) see Appendix 4.
- If a patient lives outside the LGA the consultative team or CPCT can provide information regarding how to link a patient to the appropriate area.

Prince of Wales Hospital (POWH)

Urgent Palliative Care advice after hours, please contact the Palliative Care registrar on call via switch at POWH 9382 2222.

Consultative Patient Service

For a referral to be made the treating teams need to be aware of, and agreeable to the Palliative Care teams involvement.
Referral can be made by paging the Palliative Care Registrar on 44343.

Inpatient Palliative Care Unit

- The POWH Palliative Care Team is a consult service that does not admit patients directly transfer to an inpatient Palliative Care unit from POWH is arranged via the Palliative Care Consult Team
- Sacred Heart Health Service and Wolper Jewish Hospital have Palliative Care inpatient beds servicing the Northern area of the South Eastern Sydney Local Health District
- Private Health Insurance is required for admission to Wolper Jewish Hospital.

- If a patient lives outside the health area the consultative team can provide information regarding how to transfer a patient to the appropriate Palliative Care inpatient unit.

Outpatient Referrals

- Please complete Internal Palliative Care Referral Form for referral from a POWH Specialist POW Referral.pdf Appendix 5 providing supporting information and return either by email SESLHD-POWH-PalliativeCare@health.nsw.gov.au or fax to 02 9382518 Please indicate on the form if patient is well enough to attend clinic for review

Referral from GP or a specialist outside of POWH please use SH CPCT Referral Form, Please see Appendix 6 Appendix 6 SH CPCT Referral Form.pdf

Community Palliative Care Team (CPCT)

- Please complete Internal Palliative Care Referral Form Appendix 5, indicating that a review in their home is preferred POW Referral.pdf
- Referral from GP or from specialist outside of POWH Please use Scared Heart CPCT Referral Form SH CPCT Referral Form.pdf Appendix 6 and email to cpct.referrals@svha.org.au
- If a patient lives outside the Sacred Heart CPCT area the consultative team or CPCT can provide information regarding how to link a patient to the appropriate area.

Section 6 – Documentation

- All consultations are documented in the electronic medical record
- Advance Care Planning and Goals of Care discussions are documented in the Advance Care Planning Record of Discussion Adhoc eMR tool
- Outpatient Specialist Clinic letters are sent by fax/email to the referring clinicians.

Section 7 - References

Australian Commission on Safety and Quality in Healthcare End of Life Care: Delivering and Supporting Comprehensive End of Life Care (May 2021)
Palliative Care Australia
World Health Organisation 2020 Palliative Care

Revision and Approval History

Date	Revision no:	Author and approval
August 2021	DRAFT	Draft version commenced.
September 2021	DRAFT	Draft for Comment period.
October 2021	DRAFT	Final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
December 2021	1	Approved at Clinical and Quality Council.

Appendices

Appendix 1: St George, Sutherland and Calvary Healthcare Referral for Specialist Palliative Care Medical Consultation Form

Referral for Specialist Palliative Care Medical Consultation	FAMILY NAME	
	GIVEN NAME	
	D.O.B. _____/_____/_____	☐ MALE ☐ FEMALE
	ADDRESS	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

TRIAGE PRIORITY

❒ **Urgent:** 1-2 weeks ❒ **Semi Urgent:** within 4 weeks

❒ **Routine:** 4-6 weeks ❒ **Non Urgent:** 6-8 weeks

Please include consultants in any ongoing correspondence

If **Urgent** (patient requires attendance at first available clinic) please call Consultant to discuss

If patient requires home based palliative care or is unable to attend clinic, please refer to CPCT : ph 9553-3444 or email SESLHD-Calvary-CPCT@health.nsw.gov.au

REFERRED BY

Name: ..... Designation: .....

Organisation: ..... Provider no: .....

Phone: ..... Fax: .....

Sign: ..... Date: ...../...../.....

PATIENT DETAILS

Title: ..... First Name: ..... Last Name: .....

Date of Birth: ...../...../..... Age: ..... Religion: .....

Address: .....

.....

Patient's Phone No's: H: ..... M: .....

Country of Birth: ..... Preferred Language: ..... Interpreter ❒ Yes ❒ No

Does the patient live alone? ❒ Yes ❒ No Is the patient or carer aware of the referral? ❒ Yes ❒ No

Other significant family/social: .....

.....

.....

ADVANCE CARE PLANNING

Is there an Advance Care Plan? ❒ Yes ❒ No ❒ Discussed ❒ Unknown *(❒ If yes, copy attached)*

Is there an Appointed Guardian? ❒ Yes ❒ No ❒ Discussed ❒ Unknown

Who is the person responsible if required? .....

Contact details: .....

Are the patient and family aiming for terminal care at home? ❒ Yes ❒ No ❒ Unsure

Please describe the patient's insight into their disease and prognosis: .....

.....

.....

STAFF SAFETY Are you aware of any potential risks to staff safety ❒ Yes ❒ No

Please describe: .....

.....

PSYCHOSOCIAL Does the patient or carer demonstrate emotional or spiritual distress? ❒ Yes ❒ No

Please describe: .....

.....

Are there any social workers/psychologists/counsellors involved in care? ❒ Yes ❒ No

If yes, please provide details: .....

.....

Are there any other Physical needs? ❒ Yes ❒ No

Please describe: : .....

.....

Referral for Specialist Palliative Care Medical Consultation	FAMILY NAME	
	GIVEN NAME	
	D.O.B. _____/_____/_____	☐ MALE ☐ FEMALE
	ADDRESS	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL INFORMATION ❒ *Or See Attached Document*

Palliative Diagnosis: .....

Allergies: .....

Other Significant Medical History: .....

.....

.....

.....

.....

REASON FOR THIS REFERRAL: *(select one or more)*

❒ **Complex Pain/Symptom Control** ❒ **End Of Life At Home** ❒ **Advance Care Planning** ❒ **Other**

.....

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SERVICE PROVIDERS

GP Name:	GP's Phone:
Specialist:	Location:
Specialist:	Location:
Community Nurses: ❒ Yes ❒ No	Other services involved:
Chemotherapy: ❒ Yes ❒ No	Radiotherapy: ❒ Yes ❒ No

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MEDICATION ❒ *Or See Attached*

MOBILITY STATUS

1. Independently Mobile	❒	4. Mobile with assistance of 1	❒
2. Mobile with walking aid	❒	5. Mobile with assistance of 2	❒
3. Mobile with Supervision	❒	6. In bed all of the time	❒

Appendix 2: Calvary Health Care Kogarah CPCT Referral Form

REFERRAL
CPCT

Calvary Health Care Sydney

(Please complete or affix Addressograph Label here)

MRN_____ DOB_____

Surname_____

Given Names_____

Please return completed form to PO Box 261, Kogarah, 1485 or Fax 9588 1635

This Information is essential for proper assessment on admission. Thank You for completing all questions.

Principal Diagnosis:_____

Date of Diagnosis: _____

Problems leading to Referral:_____

_____

Other Medical Problems: _____

_____

Allergies:_____

Other Specialists Involved:_____

_____

Relevant Treatment:

Surgery: _____ Date:_____

Surgeon: _____ Location:_____

Weight Bearing Status: _____

Chemotherapy: ❒ Yes ❒ No Location: _____ Doctor:_____ Date: _____

Radiotherapy: ❒ Yes ❒ No Location: _____ Doctor: _____ Date: _____

Investigations & Results: ***(Please enclose or transmit copies of relevant reports / results / etc)***

Current Medications & Dose	

Social Information: _____

Patients Knowledge of Present Condition: _____

Activities of Daily Living: _____

Family/Carer Information: _____

_____

Services Involved in Care: _____

_____

Referring Doctor: _____	Referring Doctor: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Signature: _____ Date: _____	Signature: _____ Date: _____
Provider _____	Provider _____

CALVARY HEALTH CARE SYDNEY
DO NOT WRITE

REFERRAL CPCT

CHCS 30.408

Referral CPCT Page 1 of 1 Reviewed/Updated: June 2011

Appendix 3: Calvary Health Care Kogarah Admission and Discharge Criteria Community Palliative Care team (CPCT)

Health South Eastern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Calvary Health Care Kogarah	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please return completed form to
PO BOX 261, Kogarah NSW 1485
P: 02 9553 3444 F: 02 9588 1635
Email: SESLHD-calvary-kogarahPCNR@health.nsw.gov.au

REFERRED BY

Name: _____ Designation: _____

Organisation: _____

Phone: _____ Fax: _____

Sign: _____ Date: _____ / _____ / _____

Please COMPLETE triage priority

Priority:

☐ **Urgent:** assess within 48 hours. Please phone on 9553-3444

☐ **Semi Urgent:** assess within 2 to 5 days.

☐ Non Urgent: assess within 6 to 13 days.

ALL CRITERIA MUST BE CONSIDERED PRIOR TO SENDING THE REFERRAL

Referral Criteria (All effort should be made to ensure criteria 1 & 2 have been met before sending the referral)

1. **The General Practitioner has agreed to palliative care involvement** ☐
2. **The resident and or family have agreed to a palliative care review** ☐
3. **The resident is imminently dying and requires palliative care review** ☐
4. **The resident has specialist palliative care needs not able to be managed with current plan** ☐
   a. **Poorly controlled symptoms including but not limited to pain, nausea, shortness of breath possibly related to an exacerbation of an existing condition**
   b. **Changes in resident function including increasing falls/reduced mobility, significant weight loss/worsening swallow, increasingly bed bound or an increase in hospital admissions**
   c. **Support and advice needed at a palliative care case conference/family meeting where the resident and/or family are experiencing complex physical/psychological issues OR where there is conflict about goals of care at end of life**

General Practitioner name	
Phone	
Fax	

Please attach copies of (if available):

1. Goals of care discussion Yes ☐
2. Advance care plan Yes ☐
3. Medication chart including PRN medications Yes ☐
4. Latest hospital discharge summary/eMR notes Yes ☐

BINDING MARGIN – NO WRITING

RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL

NO WRITING

Page 1 of 2

Health South Eastern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Calvary Health Care Kogarah	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please return completed form to
PO BOX 261, Kogarah NSW 1485
P: 02 9553 3444 F: 02 9588 1635
Email: SESLHD-calvary-kogarahPCNR@health.nsw.gov.au

REFERRED BY

Name: _____ Designation: _____

Organisation: _____

Phone: _____ Fax: _____

Sign: _____ Date: _____ / _____ / _____

Please COMPLETE triage priority

Priority:

☐ **Urgent:** assess within 48 hours. Please phone on 9553-3444

☐ **Semi Urgent:** assess within 2 to 5 days.

☐ Non Urgent: assess within 6 to 13 days.

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3. **The resident is imminently dying and requires palliative care review** ☐
4. **The resident has specialist palliative care needs not able to be managed with current plan** ☐
   a. **Poorly controlled symptoms including but not limited to pain, nausea, shortness of breath possibly related to an exacerbation of an existing condition**
   b. **Changes in resident function including increasing falls/reduced mobility, significant weight loss/worsening swallow, increasingly bed bound or an increase in hospital admissions**
   c. **Support and advice needed at a palliative care case conference/family meeting where the resident and/or family are experiencing complex physical/psychological issues OR where there is conflict about goals of care at end of life**

General Practitioner name	
Phone	
Fax	

Please attach copies of (if available):

1. Goals of care discussion Yes ☐
2. Advance care plan Yes ☐
3. Medication chart including PRN medications Yes ☐
4. Latest hospital discharge summary/eMR notes Yes ☐

BINDING MARGIN – NO WRITING

RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL

NO WRITING

Page 1 of 2

Appendix 4: Calvary Health Care Kogarah Residential Aged Care: Palliative Care Referral

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 3.0
CCID622113

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)

1 Applies to

This Policy applies to:

- All clients referred to the Community Palliative Care Team (CPCT) at Calvary Health Care Kogarah (CHCK)

2 Purpose

Consistent with our values of healing, hospitality, stewardship and respect, Calvary is committed to providing high quality care. Our values underpin the best way to manage the patient flow and available resources of the services.

The Community Palliative Care Team (CPCT) provides an ambulatory and domiciliary specialist palliative care service to people who live in the Kogarah, Hurstville, Rockdale and Sutherland Local Government Areas. This policy outlines the criteria by which clients are admitted and discharged from the Community Palliative Care Team.

3 Responsibilities

CPCT Administration Officer

Is responsible for receiving the referral and entering client information onto the electronic medical record.

CPCT Nursing Staff

Are responsible for the initial assessment to determine if the client meets the eligibility criteria.

CPCT Multidisciplinary Team

Are responsible for the ongoing assessment, management, care planning and discharge planning of the CPCT clients.

4 Policy

Admission Criteria

A person is eligible for admission to the Community Palliative Care Team (CPCT) if:

- They live in the South Cooks River, Bayside & Georges River Local Government Areas, and
- They have a diagnosis of a progressive, life limiting illness, and
- They, or their person responsible, is aware of, understands and has agreed to a palliative care referral, and

Approved by: CHCK Policy Committee	**Approved Date:** 19/06/2018
UNCONTROLLED WHEN PRINTED	**Review Date:** 19/06/2021

- They and/or their family has at least one of the following:
  - Complex pain or symptoms, associated with the life limiting illness, requiring specialist multidisciplinary team management and/or after hours support,
  - A level of emotional, spiritual and/or psychosocial distress or social problems, associated with the disease or prognosis, that requires substantial multidisciplinary team support,
  - A poor prognosis, anticipated median survival less than 3 months, (time frame depends completely upon symptom burden & clinical need), requiring End of Life Care.

Referral

- Referrals are received from General Practitioners (GPs), Acute and Sub-Acute Care Hospital, Residential Aged Care Facilities (RACFs), Community Health Services and self-referral with liaison from a GP.
- Referrers are to complete the Admission Form and CPCT Referral (CHCS 30.408) and fax to CPCT Secretary on 9588 1635 with other relevant information such as:
  - Hospital discharge summary as relevant
  - Pathology results,
  - Current medication list,
  - Radiology results, and
  - Medical correspondence
- The CPCT administration officer enters the patient's details into the electronic community health medical record.

Allocation

- All new referrals will be allocated to a CPCT Clinical Nurse Specialist (CNS) according to residential address.
- Clients will be triaged by the CNS into either the Palliative Ambulatory Care Clinic or home visit dependent on triage criteria after a telephone consultation with the allocated CPCT CNS.
- Clients are contacted within 48 hours of referral and triaged for service type and timeframe for initial assessment according to their specific needs.

Assessment, Admission and Planning

- The CPCT CNS conducts the initial assessment. If the client meets the admission criteria the CPCT nurse admits the client to the CPCT; completes the client consent form and refers the client to other CPCT multidisciplinary team members as appropriate.
- The client and/or family are given an information pack that includes information on privacy and rights and responsibilities.
- The clients will be reviewed by the appropriate multidisciplinary team members as per the patient's care plan until they are stable.- Patients are referred to private provider if CHCK does not offer this service.
- If the client remains stable, they will be reviewed in regards to discharge from CPCT and any other appropriate referrals for ongoing support.
- The client's day to day needs, i.e. personal care, transport, meals, medications, are supported by local community services and GP's.
- After hours phone numbers are given to the client and carers.
- The CPCT nurse sends a letter to the GP.

Shared Care Models

- Shared patient care models can exist with, but is not limited to, the following teams
  - Sydney Children's Hospital
  - Generalist nursing teams in the relevant LGAs
  - Specialist Chronic Disease teams (Heart Failure, RCCP, Haemodialysis service)

- The goal of shared care partnerships between the above teams and the CPCT is to provide a seamless service for clients with a life limiting illness.
- Shared care will be dependent on the client / carers' needs at any given time within the disease trajectory. This seamless service is achieved by effective handovers to primary carers' and transfers between services with the client receiving the appropriate care at the appropriate time without duplicating services.
- The option for after-hours emergency consultative phone service by the client will be available from Calvary Health Care Kogarah and active consultation and input from the CPCT nurses remains available to the client when deemed necessary by the shared care partners.

Paediatrics

- The CPCT may provide shared care in the care of children under the age of 16 years with the specialist palliative care paediatric team at Sydney Children's Hospital (SCH).
- The paediatric team is the primary provider of care and the palliative care community team provides support to paediatric clients as negotiated. Care is provided to paediatric clients by the medical and nursing staff Monday – Friday 0800 – 1630 hours.
- Discussion regarding client care planning occurs between the CPCT and the specialist paediatric palliative care team at SCH. All clients have a medical review by a Calvary palliative care medical consultant on admission to the service and the shared care relationship is established.
- The after-hours service is available for paediatric clients.
- Allied health services do not provide services to paediatric clients.

Criteria for Discharge from the CPCT

- Clients will be discharged from the Community Palliative Care Team for the following reasons:
  - If they do not require specialist palliative care support for greater than 4 weeks.
  - If the client moves out of the geographical area covered by CPCT.
  - Following the client's death.
- Clients discharged for the reason of not requiring specialist palliative care support will be discharged back into the care of the GP or other Primary Health teams and may be re-referred as their condition requires.
- Discharging of clients is done in consultation with CPCT Medical Consultant. The client's GP is notified by letter.

Admission to the Inpatient Palliative Care Unit (IPCU)

- CPCT clients may be admitted to the IPCU if required and if they meet the admission criteria. Please refer to the CHCK Policy: Policy 13: Admission Criteria and Process – Inpatient Palliative Care Unit.

5 Related Calvary Documents

- Admission Criteria and Processes – Palliative Care

6 Definitions

- **Terminal Care** death is likely; the aim is to focus on the physical, emotional and spiritual needs. Discharge is not expected.
- **Pain and Symptom Management** the client is experiencing distress from pain or a symptom related to their illness. The aim of the admission is to minimise or alleviate the distress and discharge is expected.

- **Specialist Paediatric Palliative Care Team** based at the Sydney Children's Hospital in Randwick and the Paediatric palliative care service from the Children's Hospital at Westmead and Bear Cottage, Manly.

7 References

- ACHS EQuIP National Standards – 2nd Edition:
  - Standard 5 Comprehensive Care

8 Appendix

Appendix 1

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 3.0
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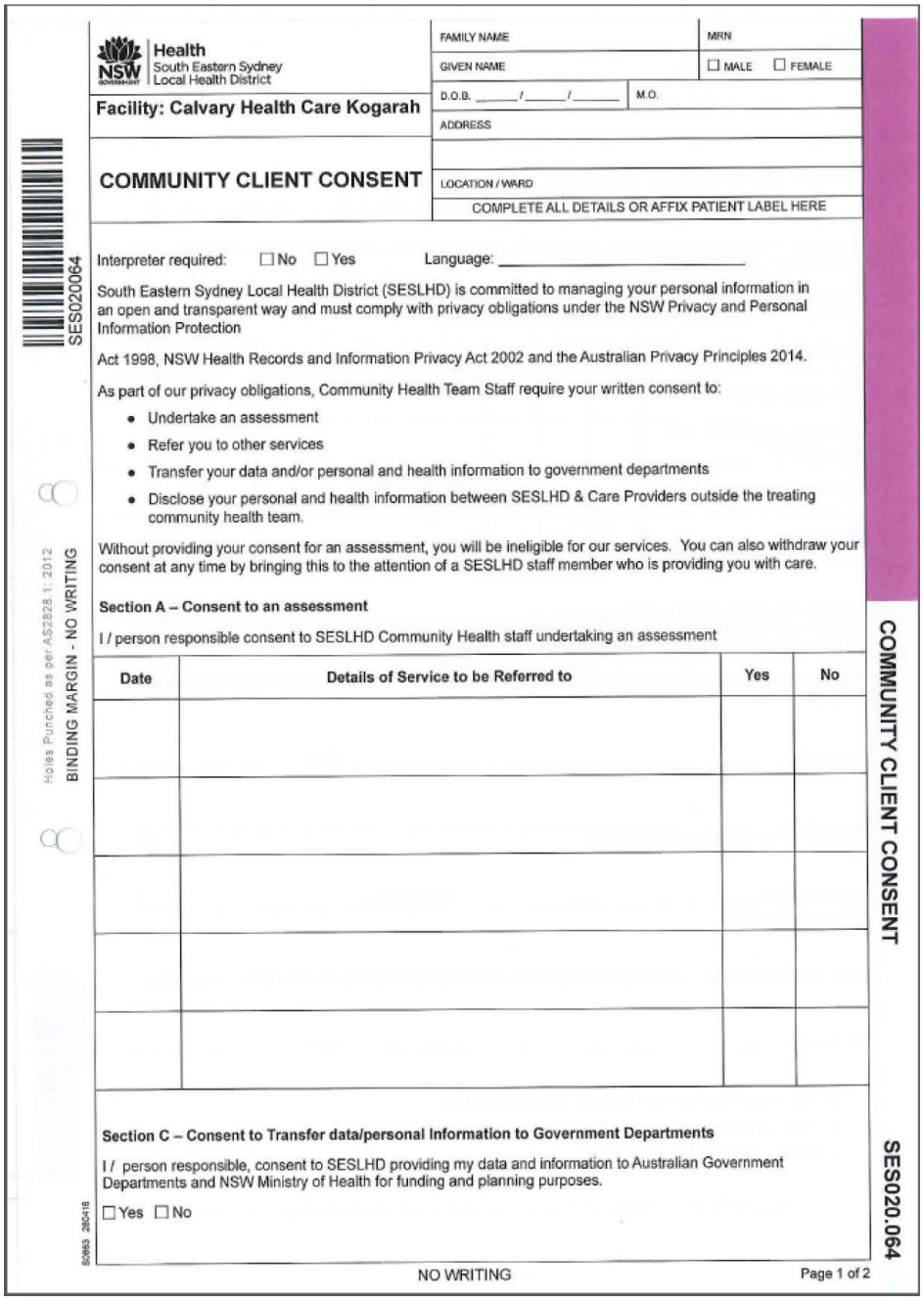

Health
South Eastern Sydney
Local Health District

Facility: Calvary Health Care Kogarah

COMMUNITY CLIENT CONSENT

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES020064

Interpreter required: ☐ No ☐ Yes Language: _____

South Eastern Sydney Local Health District (SESLHD) is committed to managing your personal information in an open and transparent way and must comply with privacy obligations under the NSW Privacy and Personal Information Protection

Act 1998, NSW Health Records and Information Privacy Act 2002 and the Australian Privacy Principles 2014.

As part of our privacy obligations, Community Health Team Staff require your written consent to:

- Undertake an assessment
- Refer you to other services
- Transfer your data and/or personal and health information to government departments
- Disclose your personal and health information between SESLHD & Care Providers outside the treating community health team.

Without providing your consent for an assessment, you will be ineligible for our services. You can also withdraw your consent at any time by bringing this to the attention of a SESLHD staff member who is providing you with care.

Section A – Consent to an assessment

I / person responsible consent to SESLHD Community Health staff undertaking an assessment

Date	Details of Service to be Referred to	Yes	No

Section C – Consent to Transfer data/personal Information to Government Departments

I / person responsible, consent to SESLHD providing my data and information to Australian Government Departments and NSW Ministry of Health for funding and planning purposes.

☐ Yes ☐ No

Holes Punched as per AS2828.1: 2012 BINDING MARGIN - NO WRITING

COMMUNITY CLIENT CONSENT

SES020.064

NO WRITING

Page 1 of 2

Approved by: CHCK Policy Committee	**Approved Date:** 19/06/2018
UNCONTROLLED WHEN PRINTED	**Review Date:** 19/06/2021

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 3.0
CCID622113

Health
South Eastern Sydney
Local Health District

Facility: Calvary Health Care Kogarah

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

COMMUNITY CLIENT CONSENT

Section D – Consent for my personal & health information to be shared between Community Health staff and other relevant care providers.

I / person responsible give consent for my personal & health information to be shared between community health staff and other relevant care providers/organisations ticked below:

Service Provider/Organisation	Yes	No	N/A	Service Provider/Organisation	Yes	No	N/A
Other SESLHD staff				Family Members (specify)			
Other Community Health Staff within SESLHD							
My General Practitioner				Others (specify):			
Medicare							

I / person responsible, (insert name) _____ confirm that the information which I have provided in sections A, B, C, & D is correct, and that SESLHD is able to access and disclose my personal, health and data information as indicated.

I / person responsible have been provided with information on brochures on Patient's Rights and Responsibilities and Patient Privacy.

Signature: _____ **Date:** _____

Relationship to client (if client unable to give consent)

Clinician Name: _____ **Designation:** _____
(Person obtaining consent)

I have explained the above and completed the patient 3 Point ID check (Name, Date of Birth, Medicare Number)

Signature: _____ **Date:** _____

- 'Rights and Responsibilities' Brochure explained and given ☐
- 'Privacy Information for Patients' Brochure explained and given ☐
- Service Brochure (if available) explained and given ☐

Please Note: Health Department client records are kept both electronically and in paper form

Page 2 of 2 NO WRITING

Holes Punched as per AS3828.1: 2012
BINDING MARGIN - NO WRITING
SES020064

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 3.0
CCID622113

Appendix 2

COMMUNITY PALLIATIVE CARE TEAM REFERRAL FORM

Calvary Health Care Kogarah

Please return completed form to
PO Box 261, Kogarah NSW 1485
P: 02 9553 3444 F: 02 9588 1635

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ___/___/___ | M.D.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRED BY
Name: ..... Designation: .....
Organisation: .....
Phone: ..... Fax: .....
Sign: ..... Date: ..... / ..... / .....

PATIENT DETAILS
Title: ..... First Name: ..... Last Name: .....
Address: .....
.....
Patient's Phone No's: H: ..... W: ..... M: .....
M ☐ F ☐ Date of Birth: ..... / ..... / ..... Age: ..... Religion: .....
Country of Birth: ..... Interpreter needed? Yes ☐ No ☐ Language: .....
Is this patient DVA? No ☐ Yes ☐ Number: .....
Is this patient currently in hospital? Yes ☐ No ☐
If yes → Hospital: ..... Proposed Discharge Date: .....

CARER DETAILS
Who should we contact regarding this referral: ☐ patient ☐ 1st contact
Has the patient consented sharing medical information with the contact person: Yes ☐ No ☐

1st Contact:	Relationship to patient:
Phone:	Lives with patient? Yes ☐ No ☐
Carer:	Relationship to patient:
Phone:	Lives with patient? Yes ☐ No ☐

Does the patient live alone? Yes ☐ No ☐
Other significant family / Social Summary: .....
.....
.....

SERVICE PROVIDERS

GP Name:	GP's Phone:
Specialist:	Clinic Location:
Specialist:	Clinic Location:
Community Nurses: Yes ☐ No ☐	Other Service Providers:

Chemotherapy: Yes ☐ No ☐ Location: ..... Doctor: ..... Date: .....
Radiotherapy: Yes ☐ No ☐ Location: ..... Doctor: ..... Date: .....

ADVANCE CARE PLANNING
Is there an Advance Care Plan? Yes ☐ No ☐ Discussed ☐ Unknown ☐ *(If yes, copy attached ☐)*
Is there an EPOA? Yes ☐ No ☐ Discussed ☐ Unknown ☐
Please describe the patient's insight into their disease and prognosis: .....
.....

CALVARY HEALTH CARE SYDNEY DO NOT WRITE

COMMUNITY PALLIATIVE CARE TEAM REFERRAL FORM

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 3.0
CCID622113

COMMUNITY PALLIATIVE CARE TEAM REFERRAL FORM

Please return completed form to
PO Box 261, Kogarah NSW 1485
P: 02 9553 3444 F: 02 9588 1635

Calvary Health Care Kogarah

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ___/___/___ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CALVARY HEALTH CARE SYDNEY
DO NOT WRITE

STAFF SAFETY

Are you aware of any potential risks to **Staff Safety** when visiting at home? Yes ☐ No ☐

Please describe: .....

PSYCHOSOCIAL

Does the patient or carer demonstrate emotional or spiritual distress? Yes ☐ No ☐

Please describe: .....

Are there any social workers/psychologists/counsellors involved in care? Yes ☐ No ☐

If yes, please provide details: .....

CLINICAL INFORMATION

Terminal Diagnosis: .....

Allergies: .....

Or See Attached Document ☐

Other Significant Medical History: .....

Or See Attached Document ☐

Reason for this Referral: .....

MEDICATION: *Or See Attached* ☐

MOBILITY STATUS:

1. Independently Mobile ☐	4. Mobile with assistance of 1 ☐
2. Mobile with walking aid ☐	5. Mobile with assistance of 2 ☐
3. Mobile with Supervision ☐	6. In bed all of the me ☐

Are there any other Physical needs? Yes ☐ No ☐

Please describe: .....

Appendix 5: Prince of Wales Hospital Internal Palliative Care Referral Form

Nelune Comprehensive Cancer Centre

Research led excellence in cancer care

THE BRIGHT ALLIANCE | UNSW AUSTRALIA

Staff Specialists:

Dr Helen Herz
Dr Gemma Ingham
Dr Jessica Borbasi

Palliative Care
Prince of Wales Hospital
Bright Building, Level 1
Randwick, NSW, 2031
Phone: (02) 9382 5108
Fax: (02) 9382 5170

Email: SESLHD-POWH-PalliativeCare@health.nsw.gov.au

Internal Palliative Care Referral Form Date of Referral: ...../...../20.....

Dear Dr .....
Department of Palliative Care
Prince of Wales Hospital

Thank you reviewing my patient ..... MRN .....

The diagnosis is .....

.....

.....

The specialist palliative care needs are.....

.....

.....

.....

.....

Thank you for arranging input from the interdisciplinary community palliative care team.

This patient is ☐ well enough to come to a palliative care clinic

☐ not as well, and review at their home is preferred

This referral will be valid for a period of 90 days.

Signature .....

Name .....

Provider No. .....

Health
South Eastern Sydney
Local Health District

A Centre for Multidisciplinary Cancer Treatment and Research
A Facility of the South Eastern Sydney Local Health District

Appendix 6: Sacred Heart Health Service Community Supportive and Palliative Care Referral Form

SACRED HEART HEALTH SERVICE

Community Supportive & Palliative Care Referral

MRN		SURNAME	
GIVEN NAME(S)			
DOB	GENDER	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

NEXT OF KIN / PERSON RESPONSIBLE	
Name:	Relationship with patient:
Address:	
Phone:	Mobile:
Email:	
CARER DETAILS Same as Next of Kin? ☐ Yes ☐ No *(If No, please complete)*	
Name:	Relationship with patient:
Address:	
Phone:	Mobile:
Email:	
INITIAL PERSON TO CONTACT	
☐ Patient	☐ Next of Kin/Person Responsible
☐ Carer	☐ Other:
SAFETY / SECURITY CONCERNS: *(Please tick all that apply)*	
☐ History of verbal/physical aggression	☐ Animals posing risk:
☐ History of drug/alcohol abuse	☐ Infection/cytotoxic risk:
☐ Behavioural Concerns	☐ Other:

GENERAL PRACTITIONER & SPECIALISTS DETAILS: *(List all relevant)*
GP aware of referral? ☐ Yes ☐ No ☐ Don't know

Name:	Address:	Phone:	Fax:	Email:
GP:				

PLEASE ATTACH ANY OF THE FOLLOWING *(Additional information can also be faxed to 02 8382 9585)*	
☐ Medical History record **MUST** be attached	☐ Discharge Summaries
☐ Current Medication list	☐ Specialists' Correspondence
☐ Advance Care Plan / Directive	☐ Recent investigations

Please email completed form to: cpct.referrals@svha.org.au
Please use file & email subject line: Community Referral [Patient Surname] [DOB DD/MM/YYYY]

Page 2 of 2

NO WRITING