South Eastern Sydney Local Health District

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 base 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: .....

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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: .....

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

Please describe: .....

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

Please describe: .....

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

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

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Are there any other Physical needs? ❒ Yes ❒ No

Please describe: : .....

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CLINICAL INFORMATION ❒ *Or See Attached Document*

Palliative Diagnosis: .....

Allergies: .....

Other Significant Medical History: .....

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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 ❒