Silver Chain

FAX: 1300 601 788

NSW REGIONAL (661) PALLIATIVE CARE LAST DAYS OF LIFE PACKAGES REFERRAL FORM

Enquiries: Contact Clinical Nurse Consultant Manager on 1300 758 566

Request date for first visit: **CNCM aware of same day referral: Yes No**

LHD: NNSWLHD MNCLHD HNELHD

CLIENT DETAILS:

Surname: First name/s: Title:

Date of Birth: MRN: Interpreter needed: Yes No Language:

Address for service delivery:

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

CARER DETAILS:

Name of main carer: Relationship to client:

Preferred contact number: Alternate phone number:

Guardian/Person responsible: Phone No:

Interpreter needed: Yes No Language:

MEDICAL HISTORY:

PCOC Phase:

Karnofsky:

Preferred place for End for Life Care:

Home PCU Hospital

Depending on symptoms or carer Undecided

WORK HEALTH AND SAFETY:

Any Risks Identified: Yes No
(specify):

If **Yes,** is a "Two Person" H/V required: Yes No

Hospital bed available: Yes No Ordered

Special instructions to access client's home:

MRO/Infectious Disease (please specify):

MEDICATIONS - to be given by Silver Chain RN

Original Medication Chart available in client's home: Yes No Script available in the home: Yes No

REFERRER/MEDICAL GOVERNANCE DETAILS:

Referred by:

Designation:

Phone No:

Date:

Referral source:

Hospital: ED Ward PCU **Or** Community Health Centre:

Referral approved by: Designation:

GP name (Medical Governance): Phone No: Fax:

GP after hours available: Yes No Phone No: Alternate A/H service & phone no:

*** Handover to be sent to:** **Contact Details:**

Intake Service/Community Health Centre

ATTACHMENTS:

Care Plan/Nursing Assessment

Health Safety Checklist

Medication Chart/Authority

PCOC Assessment or Discharge Summary

Please also include recent clinical notes, GP letters and current medication list if available

Ambulance Care Plan in Place: Yes No

Advanced Care Plan in Place: Yes No

If Phase 4:

Expected Death at Home Form:

Funeral Director Selected by Family:

Verification of Death Form available: Yes No N/A

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NSW REGIONAL PALLIATIVE CARE LAST DAYS OF LIFE PACKAGES CARE PLAN

DATE: ____________________

CLIENT DETAILS:

Surname:______________________ First name/s:____________________ Title:_____________ Date of Birth: ____________

Shower ☐ Bed Sponge ☐ Own Teeth ☐ Dentures ☐

Urine: Continent ☐ Incontinent ☐ IDC ☐ SPC ☐ Date last changed ________________

Bowels: Continent ☐ Incontinent ☐ Date last opened __________________

Comments:

SYMPTOMS:

Please tick boxes where applicable

Pain ☐ Site________________________ Subcutaneous Medications ☐ Oral Meds ☐

Syringe Driver ☐ In Progress ☐ To Commence ☐ Enema Authority ☐ Aperients ☐

Nausea ☐	Candidiasis ☐	Lymphoedema ☐	Delirium ☐
Vomiting ☐	Mouth Ulcers ☐	Anxiety ☐	Headaches ☐
Constipation ☐	Dyspnoea ☐	Fatigue ☐	Seizures ☐
Diarrhoea ☐	Cough ☐	Sleep Disturbance ☐	Agitation ☐
Dry Mouth ☐	Secretions ☐	Confusion ☐	Existential distress ☐

MANAGEMENT PLAN (PROVIDE DETAILS):

☐ Lines insitu: ____

☐ Oxygen Therapy: ____

☐ Drains: ____

☐ Wounds (incl pressure injury): ____

☐ Pacemaker / Implantable device: ____
Plans for deactivation: Yes ☐ No ☐

☐ Psychosocial: ____

☐ Spiritual needs identified: ____

☐ Religious preferences: ____

☐ Cultural Needs: ____

☐ Carer / Family concerns: ____

☐ Support systems / services in place: ____

☐ Plan for predictable catastrophic event: ____

☐ Carer educated on what to do when death occurs: ____

☐ Carer educated on administration of SC breakthrough: ____

☐ Mobility: ____

Other:____