Silver Chain

NSW METRO (660) PALLIATIVE CARE HOME SUPPORT PACKAGES (PEACH) PROGRAM REFERRAL FORM

Triple I Hub **Telephone: 1800 455 511** **Fax: (02) 4621 8799** **Email: triplei@sswahs.nsw.gov.au**

LHD: **SWSLHD ☐** **WSLHD ☐** **SLHD ☐** **ISLHD ☐** **NBMLHD ☐**

Request date for first visit: ______________________ **CNCM aware of same day referral: YES ☐ NO ☐ N/A ☐**

CLIENT DETAILS:

Surname: ______________________ First name/s: ______________________ Title: __________

Date of Birth: ______________ MRN: __________ Interpreter needed: No ☐ Yes ☐ Language: ______________

Address for service delivery: ____

Aboriginal ☐ 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: No ☐ Yes ☐ Language: ______________________

MEDICAL HISTORY:

PCOC Phase: ______________________ Karnofsky score: ______________________

Preferred place for End for Life Care: Home ☐ PCU ☐ Hospital ☐ Undecided ☐

WORK HEALTH AND SAFETY:

Any Risks Identified: No ☐ Yes ☐ (specify): ______________ Hospital Bed available: Yes ☐ No ☐ Ordered ☐

MRO/Infectious Disease (please specify) ____

MEDICATIONS:

Original Medication Chart available in client's home: Yes ☐ No ☐ To be arranged ☐ (attach if available)

Sub cut meds available in the home: Yes ☐ No ☐ To be arranged ☐

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: ______________

After Hours available Yes ☐ No ☐ Phone No: ______________________

Alternate A/H Service & Phone No: ____

Handover to be sent to: ______________________ **Fax:** ______________ **Phone No:** ______________

Intake Service/Community Health Centre

ATTACHMENTS:

MANDATORY: Care Plan OR Nursing Assessment ☐ Home Safety Checklist ☐ PCOC Assessment **OR** Discharge Summary ☐

IF AVAILABLE: Recent clinical notes ☐ Recent GP or specialist letters ☐ Verification of Death Form ☐ Ambulance Care Plan ☐

Advance Care Plan ☐ Expected Death at Home Form ☐ Funeral Director selected by family ☐