Silver Chain

Clear Form

COMMUNITY PALLIATIVE CARE SERVICE
(662) REFERRAL FORM NSW

DOB _____ PID Number/MRN

Gender _____

Title _____ Surname _____

Given Names _____

Address _____

_____ *(Affix Sticker)*

TELEPHONE 1300 758 566 **FACSIMILE (08) 9444 7265**

If urgent visit required, phone the above number and request to speak with CNCM/CC
Referral may only be made under the direction of a treating Medical Officer

Carer/Next of Kin: _____

Preferred Contact No: _____ Alternate Contact No: _____

Interpreter needed: ☐ Yes ☐ No Language: _____

Does patient have an active, progressive, terminal illness requiring symptom management? ☐ Yes ☐ No

Is the patient aware of the referral? ☐ Yes ☐ No

For inpatient referrals: Has a Supportive & Palliative Medicine consultation occurred? ☐ Yes ☐ No

If Yes, name of Palliative Clinician _____

Should presentation/admission to hospital be essential in the future:

- would admission to a palliative care unit be considered appropriate: ☐ Yes ☐ No
- would admission under specialist palliative care be considered appropriate: ☐ Yes ☐ No
- If No, which team should be contacted initially?

Diagnosis:

Summary of reasons for referral/symptom issues. Attach:

- recent letters/scans/blood results or Discharge Summary,
- if available, Advanced Medical Plan, Ambulance Care Plan, Advanced Care Directive, PCOC Assessment

Allergies	MRO

MEDICATIONS:

☐ Oxygen - Ordered by:_____ Department:_____

If injectable medications are being sent home with the patient, complete WSLHD Community Health Medication Authority WSHR - 2751ch, and attach.
Note: indicate maximum dosages over 24 hours for prn medication orders.

Medication list: Current medication list attached ☐ OR complete list over page ☐

Silver Chain

Palliative Care (662) Referral Form
New South Wales

DOB _____ PID Number/MRN

Gender _____

Title _____ Surname _____

Given Names _____

Address _____

_____ *(Affix Sticker)*

Patient has a prescription or adequate medication supplies for 5 days ☐ Yes ☐ No

Note: patient may not be reviewed by a doctor/nurse practitioner for up to 7 days.

Current treatments, therapies and devices (tick for yes)

☐ **Central Venous Access Device**

External Length _____ (to check for dislodgement) Site: _____

Date last flushed: _____ Date last dressed: _____

☐ **Drain Site** (can be multiple)

Type _____ Frequency of drainage: _____

Type _____ Frequency of drainage: _____

☐ Chemotherapy - (for cytotoxic precautions) Date last given: _____

☐ Radiotherapy - (for pain and skin care) Date of last treatment: _____

☐ Other treatments: _____

☐ Urinary Catheter - date last changed: _____

☐ Wound (for complex wounds, fax copy of current wound care plan)

☐ Stoma (type): _____ Feeding tube ☐ Yes ☐ No

Referred by: _____ Designation _____

Phone No: _____ Date: _____

Referral Source: _____ (ward/dept/centre) _____

Doctor Authorising referral: _____ Specialty (inpatients) _____

GP Name: _____ Phone No: _____ Fax: _____

GP After Hours available Yes / No Phone No: _____

DO NOT WRITE IN THIS BINDING MARGIN