Silver Chain

Clear Form

NSW REGIONAL PALLIATIVE CARE LAST DAYS OF LIFE PACKAGES REFERRAL FORM

Fax to: 1300 601 788 **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: select

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: 0 Karnofsky: select

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:** Select **Phone No:** **Fax:**

Intake Service/Community Health Centre

ATTACHMENTS

Care Plan/Nursing Assessment ☐ Home 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 N/A