|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DOB |  | | | | PID Number | |
| Gender |  | | | |  | |
| Title |  | | | Surname |  | |
| Given Names | | |  | | | |
| Address | |  | | | | |
|  | | | | | | *(Type or affix sticker)* |

|  |  |
| --- | --- |
| **IF THE REFERRAL IS URGENT PLEASE CALL US ON 1300 512 322** | |
| **If you require additional information refer to our website** | |
| **Which service are you referring to:**  Palliative Nurse Consultancy  Advanced Dementia Specialist Service  Community Specialist Palliative Care Service | |
| **Eligibility Criteria (must answer yes to all);** | |
| The client has an active, progressive, life-limiting condition (malignant or non-malignant) | Yes  No |
| Specialist palliative care advice, support, assessment and/or care at home is required for complex symptom management or relating to end of life care | Yes  No |
| The client or their substitute decision maker have been consulted and given consent for referral to the service and to receiving Palliative care at home | Yes  No |
| You would not be surprised if the client died in the next 12 months | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| Clients Full Name |  | | |
| Clients Date of Birth |  | Gender | F  M  Other |
| Clients Address |  | | |
| Clients Phone Number |  | | |
| Next of kin details (Name/Phone No.) |  | | |
| Substitute decision maker details (if client does not have capacity) |  | | |
| Interpreter required?  Yes  No | If yes, language spoken: | | |

|  |
| --- |
| **Client’s primary diagnosis:** |
| **Other relevant medical history:** |
| **Prognosis:**  Days  Weeks  Months |
| **Attach if available:**  Medication list  Discharge Summary  Scans  Pathology  Advance Care Plans |
| **Relevant psychosocial history:** |
| **Reason for referral:** |
| Symptoms and/or concerns;  Pain  Nausea  Dyspnoea  Bowels  Fatigue  Depression  Anxiety  Appetite  Insomnia  Vomiting  Functional decline  Neurological decline  Other: |
| Psychosocial distress of client and/or carer/next of kin/significant others |
| Spiritual distress of client and/or carer/next of kin/significant others |
| End of life care needs/support |

|  |
| --- |
| Client requires Community Specialist Palliative Care assessment |
| Other (give details): |
| **Safety Issues: Are there any safety concerns/potential risks to staff visiting at home you are aware of?** Yes  No  if Yes, give details: |

|  |  |
| --- | --- |
| **Client’s current location:** | |
| **Is the client a current inpatient?**  Yes  No, if Yes, **hospital?** | **Ward?** |
| **Estimated discharge:** | |
| **If client has specific needs relating to discharge such as equipment please call us on 1300 512 322** | |
| **Current Treatment:**  Yes  No, if yes, give details: | |
| **Current devices:**  Yes  No, if yes, give details: | |
| **Current Wounds:**  Yes  No, if yes, give details (please attach wound care plan): | |

|  |  |
| --- | --- |
| **Current Medical Practitioners involved in care:** | |
| **GP Name:** |  |
| **GP Address:** |  |
| **GP Phone:** |  |
| **Specialists Name:** |  |
| **Specialists Role:** |  |
| **Specialists Address:** |  |
| **Specialists Phone:** |  |

|  |  |  |
| --- | --- | --- |
| **Referrals (except for Palliative Nurse Consultancy) are ONLY accepted from Medical Practitioners or Specialist Nurse Practitioners working within a multi-disciplinary team that include medical practitioners.** | | |
| Referrers details - Name: | | |
| Position: | Location/Address: | |
| Phone: | Email: | |
| Signature/E-Signature: | | |
| Date of referral: | | |
| **Death Certificate Provision –** Contact details ofMedical Practitioner who can complete death certificate if the client dies before Silver Chain Medical Review is completed (between 3-14 days). | | |
| Name: | | Phone: |

**All referrals are reviewed within 24 hours.**

**Please send completed forms and all additional documentation via:**

**Fax to 1300601788 or via** **HealthLink EDI: VIRGINIA or email to** [**SCReferrals@silverchain.org.au**](mailto:SCReferrals@silverchain.org.au)

***Please complete this page to provide additional information, medication orders or medical orders***

|  |
| --- |
| **Additional Information:** |

**Medication and Medical Orders:** If the client requires continuous infusions, daily or breakthrough parenteral medications or any interventions (e.g. drainage or device flushes) please provide valid orders below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Micro Alerts and Allergies – Details:** |  | | | | | |
| **Medication** | **Dose** | **Frequency** | **Route** | | **Indication** | **Signed** |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
| **Prescribers Name:** | | | | **Prescriber Number:** | | |
| **Prescribers Signature:**  **Date:** | | | | | | |

**Drainage Authorisations:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drain site** | **Amount** | **Frequency** | **Doctors Name & Signature** |
|  |  |  |  |
| Parameters (BP, etc.) |  | | |