Silver Chain

DOB _____ PID Number/MRN

Gender _____

Title _____ Surname _____

Given Names _____

Address _____

_____ *(Affix Sticker)*

COMMUNITY PALLIATIVE CARE SERVICE (662) REFERRAL FORM NSW

TELEPHONE 1300 758 566 FACSIMILE 1300 601 788

If urgent visit required, phone the above number and request to speak with Clinical Nurse Manager or Case Coordinator
Referral may only be made under the direction of a treating Medical Officer

Client Contact No:_____ Alternate Contact No: _____

Carer/Next of Kin: _____

Carer/NOK Contact No: _____Alternate Contact No: _____

Interpreter needed: ☐ Yes ☐ No Language: _____

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

Have end of life discussions occurred and is the patient/family aware of this referral? ☐ Yes ☐ No

Is the patient an Inpatient? ☐ Yes ☐ No. If Yes, where _____

Diagnosis/past medical history:

Summary of reasons for referral/symptom issues.

Please attach the following recent documents if available - Medical letters, scans, blood results, Discharge Summary, Advanced Medical Plan, Advanced Care Directive, PCOC Assessment

Goals of Care: Is the patient for ☐ no CPR, ☐ no ICU.

Please list other Goals of Care and attach any documentation available

Allergies	MRO

MEDICATIONS:

Medication list: Current medication list attached ☐ OR complete list below ☐

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.

Palliative Care (662) Referral Form
New South Wales

DOB _____ PID Number/MRN
Gender _____
Title _____ Surname _____
Given Names _____
Address _____
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Current treatments, therapies and devices (tick for yes)

☐ Urinary Catheter - date last changed: _____

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

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

☐ **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: _____

Referred by: _____ Designation _____

Email: _____ Phone No: _____

Fax 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