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

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| **IF THE REFERRAL IS URGENT, PLEASE CALL US ON 1300 512 322** |
| **If you require additional information refer to our website** |
| **Eligibility Criteria (must answer yes to all);** |
| The client has a 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 |
| Is it likely the client will die in the next year, months, weeks, or days? | [ ]  Yes [ ]  No |

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| --- | --- |
| 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:       |

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| **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):       |

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| **Safety Issues: Are there any safety concerns/potential risks to staff visiting at home you are aware of?** Yes [ ]  No [ ]  if Yes, give details:       |

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| **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):       |

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

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| **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**

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

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| **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** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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|       |       |       |       |       |       |
| **Prescribers Name:**       | **Prescriber Number:**       |
| **Prescribers Signature:**       **Date:**       |

**Drainage Authorisations:**

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