|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral To** | | | | | | | | | |
|  | **Mercy Palliative Care Sunshine**  **Community Palliative Care**  3 Devonshire Road  Sunshine, VIC 3020  1300 369 019 (phone)  03 9364 9198 (fax BH)  03 8754 3741 (fax AH) | |  | **Werribee Mercy Hospital**  **Inpatient Gabrielle Jennings Centre**  300 Princes Highway  Werribee, VIC 3030  03 8754 3731 (phone)  03 8754 3735 (fax) | |  | **Non-malignant SMART Outpatients Clinic**  **Werribee Mercy Hospital**  300 Princes Highway  Werribee, VIC 3030  03 8754 6710 (fax) | | |
| **Provider No:** | | |  |
| **Signature:** | | |  |
| **Referrer Details** | | | | | **Patient Details** | | | | |
| **Surname:** | |  | | | **Surname:** | | |  | |
| **First Name:** | |  | | | **Given Name(s):** | | |  | |
| **Address:** | |  | | | **Address:** | | |  | |
| **Phone:** | |  | | | **Phone:** | | |  | |
| **Mobile:** | |  | | | **Mobile:** | | |  | |
| **Email:** | |  | | | **Email:** | | |  | |
| **Relationship:** | |  | | | **Gender:** | | | Male Female Intersex | |
| **Primary Carer / NOK** | | | | | **Date of Birth:** | | |  | |
| **Surname:** | |  | | | **Country of Birth:** | | |  | |
| **First Name:** | |  | | | **Indigenous:** | | | No Aboriginal TS Islander | |
| **Address:** | |  | | | **Preferred Language:** | | |  | |
| **Phone:** | |  | | | **Interpreter Needed:** | | | Yes No | |
| **Mobile:** | |  | | | **Diagnosis:** | | | Malignant Non-Malignant | |
| **Email:** | |  | | | **General Practitioner** | | | | |
| **Relationship:** | |  | | | **Name:** | | |  | |
| **Secondary Carer / NOK** | | | | | **Clinic:** | | |  | |
| **Surname:** | |  | | | **Address:** | | |  | |
| **First Name:** | |  | | | **Phone:** | | |  | |
| **Address:** | |  | | | **Fax:** | | |  | |
| **Phone:** | |  | | | **Email:** | | |  | |
| **Mobile:** | |  | | | **Medicare / Insurance** | | | | |
| **Email:** | |  | | | **Medicare No:** | | |  | |
| **Relationship:** | |  | | | **PH Insurance:** | | | Yes No | |
| **Other Carer / Case Manager** | | | | | **PHI Provider:** | | |  | |
| **Surname:** | |  | | | **PHI Card Number:** | | |  | |
| **First Name:** | |  | | | **DVA:** | | |  | |
| **Address:** | |  | | | **DVA Card Number:** | | | No Gold White | |
| **Phone:** | |  | | | **Other Information** | | | | |
| **Mobile:** | |  | | |  | | | | |
| **Email:** | |  | | |  | | | | |
| **Relationship:** | |  | | |  | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:** |  | | | | **DOB:** |  | | **UR/MRN:** | |  |
| **Service requested:** | IPPC IPPC Back Up Bed Community Palliative Care Outpatient Clinic | | | | | | | | | |
| **Reason for Referral:** | Symptom Management EOLC Other: | | | | | |  | | | |
| **Priority:** | Urgent *(within 2 days)* Semi-urgent *(can wait 1 week)* Non-urgent | | | | | | | | | |
| **Diagnosis / Recent History / Planned Treatments** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Past Medical History** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Clinical Information Supporting Referral for Service** | | | | | | | | | | |
| **Phase of Care:** | Stable Unstable Deteriorating Terminal | | | | | | | | | |
| **Physical Symptom** | **Additional Information** | | | | | | | | | |
| Pain |  | | | | | | | | | |
| Dyspnoea |  | | | | | | | | | |
| Nausea |  | | | | | | | | | |
| Vomiting |  | | | | | | | | | |
| Bowel |  | | | | | | | | | |
| Tiredness |  | | | | | | | | | |
| Appetite |  | | | | | | | | | |
| Other |  | | | | | | | | | |
| **Psychological Symptom Issues:** | Anxiety Depression Confusion Restlessness Existential Distress Other | | | | | | | | | |
| **Family / Caregiver Issues:** | Anxiety Distress Exhaustion Unable to meet care needs No carer Complex Need | | | | | | | | | |
| Lives alone Lives with family/other | | | | | | | | | |
| Significant health issues: | | |  | | | | | | |
| **Current interventions:** | Oxygen Syringe Driver IDC Ext. Drains PPM/AICD Wound | | | | | | | | | |
| Other: | | |  | | | | | | |
| **TO ACTION THIS REFERRAL THE FOLLOWING IS MANDATORY** | | | | | | | | | | |
| DISCHARGE SUMMARY  PATHOLOGY & RADIOLOGY REPORTS  EQUIPMENT PROVIDED | | OTHER RELEVANT CLINICAL INFORMATION  ANTICIPATORY MEDICATION ORDERS  SERVICES ARRANGED OR IN PLACE | | | | | | | **ADDITIONAL INFORMATION CAN BE ATTACHED** | |
| **MERCY HEALTH USE ONLY Referral Accepted:** | | | YES NO | | | | | | | |