Confidential Referral Cover Sheet

Please acknowledge this referral by completing the acknowledgement below (or in the covering email) and returning it by fax, email or mail.

Date Sent:

Number of Pages (including cover sheet):

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

or affix label here

Referral to:

Name: Daniela/Faye

Position: Referral Clerk

Agency: Mercy Palliative Care

Phone: 9364 9777

Fax: 9364 9198

Email:

Address: 3 Devonshire Road
Sunshine 3020

Agency/Service Provider sending referral:

Name:

Position:

Agency:

Phone:

Fax:

Email:

Address:

Priority

☐ Routine - *attend in date order (may include consumer being placed on waiting list)*

☐ Urgent - *cannot wait (consult the service by phone before forwarding this referral)*

Attachments

☐ Consumer Information	☐ Summary & Referral	☐ Consumer Consent
☐ Service Coordination Plan	☐ Living Arrangements Profile	☐ Functional Profile
☐ Health Conditions Profile	☐ Psychosocial Profile	☐ Health Behaviours Profile
☐ Functional Assessment Summary	☐ Palliative Care Clinical Referral	☐ Other:

Notes

Referral Acknowledgement

Please be advised that the above referral has been received and:

☐ **The referral is accepted**. Estimated date of assessment / admission / first visit:

or

☐ **The referral is not proceeding** for the following reason(s):

☐ Consumer declining	☐ Waiting list time inappropriate for consumer	☐ Ineligible for services	☐ Inappropriate referral	☐ Other

Comments and any further actions undertaken (*if referral is not proceeding*):

Date Acknowledged: Name: Position:

Produced by the Victorian Department of Human Services, 2006

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Consumer details

Family Name:

Given Names:

Date of Birth:

Is the date of birth estimated? ☐ Yes ☐ No

Preferred Name/s:

Sex: ________ **Title:** ________

Contact Address (*for correspondence, home visits etc*)

Usual Address (*if different from contact address*)

Contact phone number/s *(mark preferred number)*	Can leave message?	
☐ Home:	☐ Yes	☐ No
☐ Work:	☐ Yes	☐ No
☐ Mobile:	☐ Yes	☐ No
☐ Email:	☐ Yes	☐ No

Country of Birth: ________

Indigenous: ☐ No ☐ Aboriginal ☐ TS Islander

Interpreter Needed: ☐ No ☐ Yes

Preferred Language: ________

Communication: ☐ Spoken ☐ Sign language ☐ Other non-spoken ☐ Little / none ☐ Child under 5

General Practitioner *(if no GP, write NA)*

Name:

Address:

Phone:

Fax:

Email:

Contacts

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name:

Contact Address

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: ________

Is this person the consumer's carer? ☐ Yes ☐ No

Person 2 Name:

Address:

Phone:

Government Pension / Benefit:

☐ Age Pension ☐ DVA Pension ☐ Disability

☐ Carer Payment ☐ Unemployment ☐ Other

☐ None

Health Care Card Number:

Medicare Card number:

Private Health Insurance:

Insurer name:

Card number:

DVA Card Entitlement:

☐ Gold ☐ White ☐ Other ☒ None

DVA card number:

Compensables Funding Source:

☐ N/A ☐ TAC ☐ DVA ☐ Workcover

Comments:

Produced by the Victorian Department of Human Services, 2006

This form completed by:

Name: Position / Agency:

Date: Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of issues (*see Palliative Care Clinical Referral form for further details*)

Current presentation/episode, presenting problem(s) (*observed or described features; screening evidence*):

Significant Histories, Recent and past history (*medical, functional/daily living skills, social, emotional etc.*):

Medications (*list medications at time of referral, do not include dosages*):

Other:

Alerts

Allergies:

Risks: ☐ None identified ☐ Consumer at risk ☐ Care worker at risk ☐ Others at risk

Details:

Additional comments including urgency:

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This form completed by:

Name: Position / Agency:

Date: Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Current Services

Record services used in the last three months. Consider all health and community services.

Agency	Service Type	Record contact details or other information as appropriate

Referral Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required.

Date Referral/s Sent:

Agency	Service Type	Phone Number	Purpose of Referral	Consumer Consent	Referral Method	Feedback to

Produced by the Victorian Department of Human Services, 2006

This form completed by:

Name: Position / Agency:

Date: Contact number:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 1 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Referral

Referral Type (*check one only*):

- ☐ 1 To Community based service
- ☐ 2 To inpatient service, for admission ASAP
- ☐ 3 To inpatient service, for respite
- ☐ 4 Backup info only, not seeking admission at present

ECOG Status (*check one only*):

- ☐ 0 Fully active, full pre-disease performance
- ☐ 1 Ambulatory, capable of light house/office work
- ☐ 2 Ambulatory, cannot work but can self-care
- ☐ 3 In bed or chair over 50% of time, limited self-care
- ☐ 4 Confined to bed or chair, can't self-care

Is the Client an Inpatient? ☐ Yes ☐ No

Ward / Clinic:

Reason for Admission:

Expected discharge date:

Consultant:

Contact:

Medical History

Diagnosis (*inc. histology if applicable*):

Date of diagnosis:

Additional Medical History (*to supplement information in Summary & Referral form - include stage of disease, results of recent investigations, symptom control issues, summary treatment history, e.g. chemotherapy, radiotherapy, surgery, transfusions, etc, and relevant past medical history*):

Produced by the North and West Metropolitan Region Palliative Care Consortium, 2007

This form completed by:

Name:

Position / Agency:

Date:

Contact number:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 2 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Treatment

Key Symptom Issues: ☐ Pain ☐ Nausea ☐ Anorexia ☐ Constipation ☐ Diarrhoea ☐ Breathlessness ☐ Anxiety ☐ Fatigue Other:

Current Treatment (*including chemotherapy regimens / radiotherapy plans if applicable - see Summary & Referral form for medications*):

Advance Care Plans (*client understanding of pall. care, and discussions re NFR, antibiotics, transfusions, radiotherapy*):

Nursing Care

Personal Care: Does the client have difficulty or need assistance with dressing or grooming, bathing or showering, or other personal care?	☐ Yes ☐ No Details:
Continence: Does the client require continence management, e.g. IDS, pads?	☐ Yes ☐ No Details:
Mobility: Does the client have difficulty or need assistance with mobility, e.g. walking or moving around the house? Do they need or have any aids, e.g. a wheelchair?	☐ Yes ☐ No Details:

Falls Risk:

Nursing Issues (*e.g. peg feed, nasogastric tube in situ, tracheostomy, home oxygen*):

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This form completed by:

Name: Position / Agency:

Date: Contact number:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 3 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Living Arrangements and Psychosocial Issues

Living Arrangements: ☐ 1 Lives alone ☐ 2 Lives with carer ☐ 3 Lives in supported accommodation

Social Support (*comment on personal and social support, including social isolation and family and personal relationships*):

Is the client aware of the diagnosis and prognosis? ☐ Yes ☐ No If not, why?

Is the family aware of the diagnosis and prognosis? ☐ Yes ☐ No If not, why?

Has a family meeting been held? ☐ Yes ☐ No

If yes: ☐ Inpatient setting ☐ Community setting Date:

Psychosocial Issues (*e.g. family & personal relationships, previous losses, family problems, concurrent life crises*):

Cultural considerations:

Challenging Behaviours: Does the person have behavioural problems, for example aggression, wandering or agitation?	☐ Yes ☐ No Details:
Cognition: Does the person have memory problems or get confused?	☐ Yes ☐ No Details:
Religion: Parish:	Spiritual screening attended? ☐ Yes ☐ No Pastoral care contact:

Multidisciplinary Assessments

Have any relevant assessments been carried out (e.g. Aged Care, Physiotherapy, OT, Social Work, Volunteer or other)? Please list type of assessment, and contact details of assessing practitioner. Please include or attach assessment summaries.

Assessment	Assessor Name and Phone Number	Notes
Aged Care		

Other Information

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This form completed by:

Name: Position / Agency:

Date: Contact number: