

**MERCY PALLIATIVE CARE**

**Ph 03 9313 5700 Fax 03 9364 9198**

**Facsimile**

|  |  |  |  |
| --- | --- | --- | --- |
| To:  | Intake Coordinator, Mercy Palliative Care  | From:  | Click or tap here to enter text. |
| Fax No: | 9364 9198 | Reply Fax: | Click or tap here to enter text. |
| Cc: |  | Reply Ph: | Click or tap here to enter text. |
| Date: | 19 February 2020 |
| Re:  | Request for Mercy Palliative Care Review |
|  |  |  |  |

**IMPORTANT** – This message is intended only for the use of the individual or entity names above and may contain information that is confidential and privileged. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you received this communication in error, please notify us immediately by telephone and destroy the message. Thank you.

**Home Address or Residential Care Facility**

|  |  |
| --- | --- |
| **Facility Name:\*if applicable** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Phone number:** | Click or tap here to enter text. |
| **Contact Person:** | Click or tap here to enter text. |

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname:** | Click or tap here to enter text. | **DOB:** | Click or tap here to enter text. |
| **Given Name:** | Click or tap here to enter text. | **Mercy Health UR No:**(if known) | Click or tap here to enter text. |
| **Medicare No:** | Click or tap here to enter text. | **Country of Birth:** | Click or tap here to enter text. |
| **GP:** | Click or tap here to enter text. | **Preferred Language:** | Click or tap here to enter text. |
| **GP Ph No:** | Click or tap here to enter text. |  |  |

**The following referral information is included: \* Denotes mandatory referral information**

[ ]  Registration details (also include NOK/medical treatment decision marker / advanced care directive)\*

[ ]  Mercy Palliative Care ISBAR Referral \*

[ ]  Recent medical/hospital correspondence\*

[ ]  X-Rays / CT / MRI / PET / Pathology reports (if applicable)

[ ]  Hospital discharge summary (if applicable)

Please sign below to confirm you are aware that incomplete referrals could delay the review process

Signature ………………………………………………….. Name: …………………………………..

|  |  |
| --- | --- |
| Mercy Palliative Care | UR No:Surname:Given Name:DOB:*OR Attach Patient Label here* |

**ISBAR REFERRAL FOR PALLIATIVE CARE REVIEW**

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| --- | --- |
| **DATE:**  | **Phone: 1300 369 019 Fax: 9364 9198** |
| **Identify**[ ]  **Consent from patient for referral** (if not, state reason) Click or tap here to enter text.[ ]  **GP Details:** (if not already included) Click or tap here to enter text.[ ]  **Consent from GP for referral** (if not, state reason) Click or tap here to enter text.[ ]  **Consent from family for referral** (if not, state reason) Click or tap here to enter text. |
| **Situation** *(Diagnoses / Reason for referral)*[ ]  **Diagnoses:** *(if not state reason)* Click or tap here to enter text.**Reason for referral:** *(please tick*)[ ]  Symptom management [ ]  Support for anticipated deterioration [ ]  End of Life Care |
| **Background** *(Relevant medical & social history)***Past medical history:**Click or tap here to enter text.**Medications:** *(or attached copy of medication chart* [ ]  *)*Click or tap here to enter text.**Allergies/Sensitivities:** Click or tap here to enter text.**Social history:**Click or tap here to enter text.**Advanced care directive/medical treatment decision maker:** *(please attach copy / details)* Click or tap here to enter text. |

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| **Assessment** *(Actions taken / Relevant investigations / Impression of situation / risk identified)***Cognitive State:** [ ]  Alert [ ]  Confused [ ]  Agitated [ ]  DrowsyClick or tap here to enter text.**Functional status:**  [ ]  Independent/supervision [ ]  Chair bound [ ]  Bed BoundClick or tap here to enter text.**Nutrition:**  [ ]  Full/Normal [ ]  Deteriorating [ ]  Nil **Route:**  [ ]  Oral [ ]  NG [ ]  PEG [ ]  Nil Click or tap here to enter text.**Clinical Symptoms:**[ ]  controlled with medication/s [ ]  requiring PRNs [ ]  not controlled with medication/sClick or tap here to enter text.**Impression of situation/problem** (include any actions taken):Click or tap here to enter text. |
| **Request** *(Desired outcome of review)*Click or tap here to enter text. |