MERCY PALLIATIVE CARE
Ph 03 9313 5700 Fax 03 9364 9198

Mercy Health
Care first

Facsimile

To:	Intake Coordinator, Mercy Palliative Care	From:	
Fax No:	9364 9198	Reply Fax:	
Cc:		Reply Ph:	
Date:			
Re:	**Request for Mercy Palliative Care Review**		

☐ Urgent ☐ Routine ☐ Please Comment ☐ Please Reply

Home Address or Residential Care Facility

Facility Name: *if applicable	
Address:	
Phone number:	
Contact Person:	

Patient details

Surname:		**DOB:**	
Given Name:		**Mercy Health UR No:** (if known)	
Medicare No:		**Country of Birth:**	
GP:		**Preferred Language:**	
GP Ph No:			

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

ISBAR REFERRAL FOR PALLIATIVE CARE REVIEW

DATE:	**Phone: 1300 369 019 Fax: 9364 9198**

Identify

☐ **Consent from patient for referral** (if not, state reason)

☐ **GP Details:** (if not already included)

☐ **Consent from GP for referral** (if not, state reason)

☐ **Consent from family for referral** (if not, state reason)

Situation *(Diagnoses / Reason for referral)*

☐ **Diagnoses:** *(if not state reason)*

Reason for referral: *(please tick)*

☐ Symptom management ☐ Support for anticipated deterioration ☐ End of Life Care

Background *(Relevant medical & social history)*

Past medical history:

Medications: *(or attached copy of medication chart ☐)*

Allergies/Sensitivities:

Social history:

Advanced care directive/medical treatment decision maker: *(please attach copy / details)*

Mercy Palliative Care

3 Devonshire Road (PO Box 178), Sunshine Vic 3020 Phone 03 9313 5700 Facsimile 03 9364 9198 ABN 77 896 699 763

Assessment *(Actions taken / Relevant investigations / Impression of situation / risk identified)*

Cognitive State: ☐ Alert ☐ Confused ☐ Agitated ☐ Drowsy

Functional status: ☐ Independent/supervision ☐ Chair bound ☐ Bed Bound

Nutrition: ☐ Full/Normal ☐ Deteriorating ☐ Nil **Route:** ☐ Oral ☐ NG ☐ PEG ☐ Nil

Clinical Symptoms:
☐ controlled with medication/s
☐ requiring PRNs
☐ not controlled with medication/s

Impression of situation/problem (include any actions taken):

Request *(Desired outcome of review)*

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