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| SMART ClinicSupplementary Information |  | **Referral Date:** 15/01/2020 **General enquiries:**Ph 1300 369 019 (24 hours) |

 Referral to

|  |  |  |
| --- | --- | --- |
| [x]  SMART (Symptom Management and Referral Team) clinic | Phone: 8754 6700Fax: 8754 6710 | Outpatient Clinics, Werribee Mercy Hospital |
| This document **must** be attached to the 2 page [Werribee Mercy Hospital Outpatient Clinic Referral form](https://health-services.mercyhealth.com.au/health-professionals/refer-a-patient/referral-instructions-and-templates/#content-referral-forms--templates) when referring to the SMART clinic. **This document in isolation does not constitute a valid referral.** |

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|  Patient Details |
| Last/Family name:  | First name: |
| Date of birth: | Sex: Choose an item. |
| Address: |  |
| Suburb: | Home telephone No.: |
| Postcode: | Mobile number: |

 Referring Doctor Details

|  |  |
| --- | --- |
| Referring Doctor: |  |
| Practice Name: |  |

Additional medical history/treatment

|  |  |
| --- | --- |
| Primary diagnosis (include histology if applicable): | Secondary diagnosis: |
|  |  |
| Date of primary diagnosis (dd/mm/yyyy) / / | Date of secondary diagnosis dd/mm/yyyy / / |
| **Additional medical history** (attach relevant imaging, blood test results, medication list etc) |
|  |

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| **Key Symptom issues:** |
| [ ]  Pain | [ ]  Tiredness | [ ]  Nausea | [ ]  Depression | [ ]  Anxiety | [ ]  Shortness of breath |
| [ ]  Drowsiness | [ ]  Appetite | [ ]  Wellbeing | [ ]  Constipation | [ ]  Diarrhoea | [ ]  Other: |
| Advance Care Planning |
| Does the consumer have an Advance Care Plan? | [ ]  Yes [ ]  No [ ]  Not stated/unknown | If yes, where is it kept? |
| Does this include a Refusal of Treatment Certificate or other documentation limiting treatment? | [ ]  Yes [ ]  No [ ]  Not stated/unknown |
| Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions? | [ ]  Yes [ ]  No [ ]  Not stated/unknown | If yes, name of substitute decision maker? |

|  |  |  |
| --- | --- | --- |
| 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? |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor’s signature: |  | Date: |  |

**Appointment details will be sent to referring GP and the patient.**

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