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

Referral to

|  |  |  |
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| SMART (Symptom Management and Referral Team) clinic | Phone: 8754 6700  Fax: 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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