## **SMART** Clinic

# Supplementary Information



#### Referral to

	SMART (Symptom Management and Referral Team) clinic	Phone: 8754 6700 Fax: 8754 6710	Outpatient Clinics, Werribee Mercy Hospital
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This document **must** be attached to the 2 page <u>Werribee Mercy Hospital Outpatient Clinic Referral form</u> when referring to the SMART clinic. **This document in isolation does not constitute a valid referral.** 

### **Patient Details**

Last/Family name:	First name:
Date of birth:	Sex:
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:				
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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)					

Key Symptom issues:							
🗆 Pain	□ Tiredness	Nausea	Depression	Anxiety	□ Shortness of breath		
□ Drowsiness	□ Appetite	Wellbeing	□ Constipation	Diarrhoea	□ Other:		
Advance Ca	Advance Care Planning						
Does the consum	er have an Advance (	Care Plan?	□ Yes □ No □	Not stated/unknow	h If yes, where is it kept?		
	boes this include a Refusal of Treatment Certificate or ther documentation limiting treatment? □ Yes □ No □ Not stated/unknown		n				
Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?		□ Yes □ No □	Not stated/unknow	If yes, name of substitute decision maker?			
Is the client aware of the diagnosis and prognosis?		🗆 Yes 🗆 No	If not, why?				
Is the family awar	e of the diagnosis and	d 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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