

REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE SERVICES

Referral To			
<input type="checkbox"/> Mercy Palliative Care Sunshine Community Palliative Care 3 Devonshire Road Sunshine, VIC 3020 1300 369 019 (phone) 03 9364 9198 (fax BH) 03 8754 3741 (fax AH)	<input type="checkbox"/> Werribee Mercy Hospital Inpatient Gabrielle Jennings Centre 300 Princes Highway Werribee, VIC 3030 03 8754 3731 (phone) 03 8754 3735 (fax)	<input type="checkbox"/> Non-malignant SMART Outpatients Clinic Werribee Mercy Hospital 300 Princes Highway Werribee, VIC 3030 03 8754 6710 (fax)	
		Provider No:	
		Signature:	
Referrer Details		Patient Details	
Surname:		Surname:	
First Name:		Given Name(s):	
Address:		Address:	
Phone:		Phone:	
Mobile:		Mobile:	
Email:		Email:	
Relationship:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex
Primary Carer / NOK		Date of Birth:	
Surname:		Country of Birth:	
First Name:		Indigenous:	<input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> TS Islander
Address:		Preferred Language:	
Phone:		Interpreter Needed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile:		Diagnosis:	<input type="checkbox"/> Malignant <input type="checkbox"/> Non-Malignant
Email:		General Practitioner	
Relationship:		Name:	
Secondary Carer / NOK		Clinic:	
Surname:		Address:	
First Name:		Phone:	
Address:		Fax:	
Phone:		Email:	
Mobile:		Medicare / Insurance	
Email:		Medicare No:	
Relationship:		PH Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Carer / Case Manager		PHI Provider:	
Surname:		PHI Card Number:	
First Name:		DVA:	
Address:		DVA Card Number:	<input type="checkbox"/> No <input type="checkbox"/> Gold <input type="checkbox"/> White
Phone:		Other Information	
Mobile:			
Email:			
Relationship:			

REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE SERVICES

Client Name:		DOB:		UR/MRN:	
Service requested:	<input type="checkbox"/> IPPC <input type="checkbox"/> IPPC Back Up Bed <input type="checkbox"/> Community Palliative Care <input type="checkbox"/> Outpatient Clinic				
Reason for Referral:	<input type="checkbox"/> Symptom Management <input type="checkbox"/> EOLC <input type="checkbox"/> Other:				
Priority:	<input type="checkbox"/> Urgent (<i>within 2 days</i>) <input type="checkbox"/> Semi-urgent (<i>can wait 1 week</i>) <input type="checkbox"/> Non-urgent				
Diagnosis / Recent History / Planned Treatments					
Past Medical History					
Clinical Information Supporting Referral for Service					
Phase of Care:	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Terminal				
Physical Symptom	Additional Information				
<input type="checkbox"/> Pain					
<input type="checkbox"/> Dyspnoea					
<input type="checkbox"/> Nausea					
<input type="checkbox"/> Vomiting					
<input type="checkbox"/> Bowel					
<input type="checkbox"/> Tiredness					
<input type="checkbox"/> Appetite					
<input type="checkbox"/> Other					
Psychological Symptom Issues:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Confusion <input type="checkbox"/> Restlessness <input type="checkbox"/> Existential Distress <input type="checkbox"/> Other				
Family / Caregiver Issues:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Distress <input type="checkbox"/> Exhaustion <input type="checkbox"/> Unable to meet care needs <input type="checkbox"/> No carer <input type="checkbox"/> Complex Need				
	<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with family/other				
	<input type="checkbox"/> Significant health issues:				
Current interventions:	<input type="checkbox"/> Oxygen <input type="checkbox"/> Syringe Driver <input type="checkbox"/> IDC <input type="checkbox"/> Ext. Drains <input type="checkbox"/> PPM/AICD <input type="checkbox"/> Wound				
	<input type="checkbox"/> Other:				
TO ACTION THIS REFERRAL THE FOLLOWING IS MANDATORY					
<input type="checkbox"/> DISCHARGE SUMMARY		<input type="checkbox"/> OTHER RELEVANT CLINICAL INFORMATION		ADDITIONAL INFORMATION CAN BE ATTACHED	
<input type="checkbox"/> PATHOLOGY & RADIOLOGY REPORTS		<input type="checkbox"/> ANTICIPATORY MEDICATION ORDERS			
<input type="checkbox"/> EQUIPMENT PROVIDED		<input type="checkbox"/> SERVICES ARRANGED OR IN PLACE			
MERCY HEALTH USE ONLY Referral Accepted:				<input type="checkbox"/> YES <input type="checkbox"/> NO	