|  |
| --- |
| **Referral To** |
| [ ]  | **Mercy Palliative Care Sunshine****Community Palliative Care** 3 Devonshire RoadSunshine, VIC 30201300 369 019 (phone)03 9364 9198 (fax BH)03 8754 3741 (fax AH) | [ ]  | **Werribee Mercy Hospital****Inpatient Gabrielle Jennings Centre**300 Princes HighwayWerribee, VIC 303003 8754 3731 (phone)03 8754 3735 (fax) | [ ]  | **Non-malignant SMART Outpatients Clinic****Werribee Mercy Hospital**300 Princes HighwayWerribee, VIC 303003 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:** | [ ] Male [ ] Female [ ] Intersex |
| **Primary Carer / NOK** | **Date of Birth:** |  |
| **Surname:** |  | **Country of Birth:** |  |
| **First Name:** |  | **Indigenous:** | [ ] No [ ] Aboriginal [ ] TS Islander |
| **Address:** |  | **Preferred Language:** |  |
| **Phone:** |  | **Interpreter Needed:** | [ ] Yes [ ] No |
| **Mobile:** |  | **Diagnosis:**  | [ ] Malignant [ ] 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:** | [ ] Yes [ ] No |
| **Other Carer / Case Manager** | **PHI Provider:** |  |
| **Surname:** |  | **PHI Card Number:** |  |
| **First Name:** |  | **DVA:** |  |
| **Address:** |  | **DVA Card Number:** | [ ] No [ ] Gold [ ] White |
| **Phone:** |  | **Other Information** |
| **Mobile:** |  |  |
| **Email:** |  |  |
| **Relationship:** |  |  |

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