MERCY PALLIATIVE CARE Ph 03 9313 5700 Fax 03 9364 9198



Facsimile

To:	Intake Coordinator, Mercy Palliativ	ve Care From:	
Fax No:	9364 9198	Reply Fax:	
Cc:		Reply Ph:	
Date:			
Re:	Request for Mercy Palliative Ca	re Review	
🗖 Urg	ent 🗖 Routine	Please Comment	Please Reply
MDODTANT	This assesses in interval and such that the same of the individual	and an analysis and an	المحمد والأرباب والمرتب والمتلاط والمتكر والمتراج والمراجع والمراجع والمراجع

IMPORTANT – This message is intended only for the use of the individual or entity names above and may contain information that is confidential and privileged. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you received this communication in error, please notify us immediately by telephone and destroy the message. Thank you.

Home Address or Residential Care Facility

Facility Name: ^{*if applicable}	
Address:	
Phone number:	
Contact Person:	

Patient details

Surname:	DOB:	
Given Name:	Mercy Health UR No:	
Given Name.	(if known)	
Medicare No:	Country of Birth:	
GP:	Preferred	
	Language:	
GP Ph No:		

The following referral information is included: * Denotes mandatory referral information

□ Registration details (also include NOK/medical treatment decision marker / advanced care directive)*

□ Mercy Palliative Care ISBAR Referral *

□ Recent medical/hospital correspondence*

□ X-Rays / CT / MRI / PET / Pathology reports (if applicable)

□ Hospital discharge summary (if applicable)

Please sign below to confirm you are aware that incomplete referrals could delay the review process

Signature Name:

Mercy Palliative Care

Page 1 of 3

3 Devonshire Road (PO Box 178), Sunshine Vic 3020 Phone 03 9313 5700 Facsimile 03 9364 9198 ABN 77 896 699 763

Compassion Hospitality Respect Innovation Stewardship Teamwork

	UR No:
	Surname:
Mercy Health	Given Name:
Care first	DOB:
Mercy Palliative Care	
	OR Attach Patient Label here

ISBAR REFERRAL FOR PALLIATIVE CARE REVIEW

DATE:	Phone: 1300 369 019 Fax: 9364 9198			
dentify				
Consent from patient for referral (if not, state reason)				
GP Details: (if not already included)				
□ Consent from GP for referral (if not, state reas	son)			
Consent from family for referral (if not, state reason)				
Situation (Diagnoses / Reason for referral)				
Diagnoses: (if not state reason)				
Reason for referral: (please tick)				
Symptom management Support for anticip	bated deterioration □ End of Life Care			
Background (Relevant medical & social h Past medical history:	istory)			
Medications: (or attached copy of medication cha	art 🗆)			
Allergies/Sensitivities:				
Social history:				
Advanced care directive/medical treatment dec	sision maker: (please attach copy / details)			

3 Devonshire Road (PO Box 178), Sunshine Vic 3020 Phone 03 9313 5700 Facsimile 03 9364 9198 ABN 77 896 699 763

Assessment (Actions taken / Relevant investigations / Impression of situation / risk identified)			
Cognitive State: Alert Confused Agitated Drowsy			
Functional status: □ Independent/supervision □ Chair bound □ Bed Bound			
Nutrition: Full/Normal Deteriorating Nil Route: Oral NG PEG Nil			
Clinical Symptoms: Clinical Symptoms: Clinical Symptoms Clinical S			
Request (Desired outcome of review)			

Page 3 of 3

Mercy Palliative Care

3 Devonshire Road (PO Box 178), Sunshine Vic 3020 Phone 03 9313 5700 Facsimile 03 9364 9198 ABN 77 896 699 763