Mercy Health
Care first

REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE SERVICES

Referral To			
☐ **Mercy Palliative Care Sunshine Community Palliative Care** 3 Devonshire Road Sunshine, VIC 3020 1300 369 019 (phone) 03 9313 5710 (fax BH) 03 8754 3741 (fax AH)	☐ **Werribee Mercy Hospital Inpatient Gabrielle Jennings Centre** 300 Princes Highway Werribee, VIC 3030 03 8754 3731 (phone) 03 8754 3735 (fax)	☐ **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:	**Fax:**	**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:**	English
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:**	Unavailable
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:			

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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	☐OTHER RELEVANT CLINICAL INFORMATION	**ADDITIONAL INFORMATION CAN BE ATTACHED**
☐PATHOLOGY & RADIOLOGY REPORTS	☐ANTICIPATORY MEDICATION ORDERS	
☐EQUIPMENT PROVIDED	☐SERVICES ARRANGED OR IN PLACE	

MERCY HEALTH USE ONLY Referral Accepted:	☐YES ☐NO