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:			

Mercy Health
Care first

REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE SERVICES

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				