Calvary | Health Care Bruce
Clare Holland House

Inpatient Palliative Care Unit

Referral Form

Ph: (02) 6264 7300 FAX: (02) 6273 0338

Clare Holland House, Palliative Care Services ACT, 5 Menindee Drive, Barton ACT 2600

Referred by

Name:………………………………………………………………………………………… Designation:………………………………..

Organisation:……………………………………………………………….. Phone:……………………………………………………..

Sign: ……………………………………………………………………………….. Fax:…………………………………………………………..

Provider Number:…………………………………………… **(Mandatory)** Date: …………………………………………………..

A Discharge Summary is required for patients referred from another Health Facility: (Attached ☐)

Patient Details

Title:	**First Name:**	**Last Name:**
Address:		
Patient's Phone No's: H: W: M:		

M ☐ F ☐	Date of Birth:	Age:	Religion:
Country of Birth?	Language Spoken?		Interpreter needed? Yes ☐ No ☐
Is this patient DVA? No ☐ Yes ☐, Number :			

Carer Details

Who should we contact regarding this referral: ☐ patient ☐ 1st contact

Has the patient consented sharing medical information with the contact person: ☐ yes

1st Contact	Relationship to patient:
Phone:	Lives with patient? Yes ☐ No ☐
2nd Contact:	Relationship to patient:
Phone:	Lives with patient? Yes ☐ No ☐

Does the patient live alone? Yes ☐ No ☐
Other significant family / Social Summary:

Service Providers:

GP Name:	GP's Phone:
Specialist:	Clinic Location:
Specialist:	Clinic Location:
Community Nurses: Yes ☐ No ☐	Other Service Providers:

Advance Care Planning

Is there an Advance Care Plan? Yes ☐ No ☐ Discussed ☐ Unknown ☐ *(If yes, please attach)*
Is there an EPOA? Yes ☐ No ☐ Discussed ☐ Unknown ☐
Please describe the patients insight into their disease and prognosis:

Psychosocial

Does the patient or carer demonstrate emotional or spiritual distress? Yes ☐ No ☐
Please describe:

Current Social Worker: Name:……………………………………. Contact phone:……………………………….

ACAT current: Yes ☐ No ☐

Nursing Care Plan (please circle)

Cognitive Status: Alert & Orientated Confused Semi-conscious Unconscious

Falls Risk: High Medium Low

Skin Integrity: Intact Existing Pressure Injury: Y N Site ……………………………………

Drains: Y N Site: ……………………………… Type:……………………………………………….

Catheters: Y N Date due to be changed: ……………………………

Bariatric Equipment: Y N Type:………………………………………………………………………..

Oxygen Requirement: Y N Type:………………………………………………………………………..

Other Care Needs: ……………………………………………………………………………………………

Clinical Information

Terminal Diagnosis:
Allergies: *See Attached Document* ☐
Other Significant Medical History: See Attached Document ☐
Reason for this Referral:
Medications: See Attached Document ☐

Please fax to: (02) 6273 0338