Triage

|  |
| --- |
| *Priority:*🞏 Urgent:assess within 48 hours. Please phone on 62647333🞏 Semi Urgent: assess within 2 to 5 days. 🞏 Non Urgent: assess within 6 to 13 days.  |

3 of 4 REFERAL CRITERIA MUST BE MET PRIOR TO SENDING THE REFERRAL

|  |
| --- |
| Referral Criteria1. The resident is terminal □
2. The General Practitioner has agreed to the service involvement □
3. The resident and or family have agreed to the service □
4. The resident has specialist palliative care needs unable to be addressed using a palliative approach □
5. Uncontrolled symptoms (pain, nausea, shortness of breath)
6. Severe symptoms related to exacerbation of an existing disease process where decision has to be made to focus on comfort care rather than cure
7. Complex care planning for a resident who has a terminal illness
8. Support and advice needed at a palliative care case conference where the resident and/family are experiencing complex physical and or psychological issues
9. End of life (terminal care) support and advice

  |
|  General Practitioner name |  |
| Phone  |  |
| Fax  |  |

**Please attach copies of:**

|  |  |
| --- | --- |
| 1. Goals of care discussion
 | Yes □ |
| 1. Advance care plan
 | Yes □ |
| 1. EPOA
 | Yes □ |
| 1. Medication chart including PRN medications
 | Yes □ |
| 1. Latest hospital discharge summary
 | Yes □ |

Patient Details

|  |  |  |
| --- | --- | --- |
| Title: |  First Name: | Last Name: |
| Facility name and address: |
| Facility phone number  |
| M 🞏 F 🞏 | Date of Birth: | Age: | Religion: |
| Country of Birth? | Language Spoken? | Interpreter needed? Yes 🞏 No 🞏 |

**Carer Details**

|  |  |
| --- | --- |
| 1st Contact  | Relationship to patient: |
| Phone: Home: Work: Mobile: |
| 2nd Contact: | Relationship to patient: |
| Phone: Home: Work: Mobile: |

**Clinical Information**

|  |
| --- |
| Terminal Diagnosis: |
| Reason for referral – What are the specialist palliative care needs that need to be addressed?  |  |
|  What has been implemented/trialed to alleviate palliative care needs using a palliative approach to care? |  |

Referred by

|  |
| --- |
| Name:………………………………………………………………………………………………… Designation:………………………………...Phone:…………………………………………………….. Fax:…………………………………………………………..Sign: …………………………………………………………………………..….……… Date: ……………………………………………………. |

**Please fax to: (02) 6273 0358**