CALVARY PUBLIC HOSPITAL BRUCE
CLARE HOLLAND HOUSE

CH-1440

PALLIATIVE AGED CARE SERVICES REFERRAL FORM

ATTACH PATIENT LABEL

Unit Record Number: ☐☐☐☐☐☐☐☐

Family Name: ____________________

Given Names: ____________________

Date of Birth: ☐☐☐☐☐☐☐☐

Age: ☐ Gender: ☐

TRIAGE

Priority:

☐ **Urgent** ☐ **Semi Urgent** ☐ **Non Urgent**

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

Referral Criteria (Criteria 1 & 2 must be met, plus either one or both of criteria 3 or 4)

1. **The General Practitioner has agreed to the service involvement** ☐
2. **The resident and or family have agreed to the service** ☐
3. **The resident is terminal** ☐
4. **The resident has specialist palliative care needs unable to be addressed using a palliative approach** ☐
   a. **Uncontrolled symptoms (pain, nausea, shortness of breath)**
   b. **Severe symptoms related to exacerbation of an existing disease process where decision has to be made to focus on comfort care rather than cure**
   c. **Complex advance care planning for a resident who has a terminal illness**
   d. **Support and advice needed at a palliative care case conference where the resident and/family are experiencing complex physical/ psychological issues OR there is conflict about goals of care at end of life**

General Practitioner name: ____________________

Phone: ____________________

Fax: ____________________

PLEASE ATTACH COPIES OF:

1. Goals of care discussion — Yes ☐
2. Advance care plan — Yes ☐
3. EPOA — Yes ☐
4. Medication chart including PRN medications — Yes ☐
5. Latest hospital discharge summary — Yes ☐

PATIENT DETAILS

Title: ____________________

First Name: ____________________

Last Name: ____________________

Facility name and address: ____________________

____

PALLIATIVE AGED CARE SERVICES REFERRAL FORM

M ☐ F ☐	Date of Birth:	Age:	Religion:

Country of Birth?	Language Spoken?	Interpreter needed? Yes ☐ No ☐

CARER DETAILS

1st Contact		Relationship to patient:
Home Phone:	Work:	Mobile:
2nd Contact		Relationship to patient:
Home Phone:	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 note: Residents who have been admitted to RACF Respite Care cannot be seen by members of the Specialist Palliative Aged Care Team.

Please fax to: (02) 6273 0358 or Email chh.agedcare@calvary-act.com.au