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| **TELEPHONE 1300 758 566** | **FACSIMILE 1300 601 788** |

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| --- | --- | --- | --- | --- | --- | --- |
| DOB |  | | | | PID Number | |
| Gender |  | | | |  | |
| Title |  | | | Surname |  | |
| Given Names | | |  | | | |
| Address | |  | | | | |
|  | | | | | | *(Type or affix sticker)* |

**If urgent visit required phone the above number and request to speak with**

**Clinical Nurse Consultant or Case Coordinator**

**Referral may only be made under the direction of a treating Medical Officer**

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| Client Contact No:       Alternate Contact No:  Carer/Next of Kin:  Carer/NOK Contact No:       Alternate Contact No:  Interpreter needed:  Yes  No Language: | | | |
| Does patient have an active, progressive, life-limiting illness requiring symptom management?  Yes  No  Have end of life discussions occurred and is the patient/family aware of this referral?  Yes  No  Is the patient an Inpatient?  Yes  No. | | | |
| If Yes, where: | |  | |
|  |  | | |
| **Diagnosis/past medical history:** | | | |
| **Summary of reasons for referral/symptom issues**    **Please attach the following recent documents if available: Medical letters, scans, blood results, Discharge Summary, Advance Medical Plan, Advance Care Directive, PCOC assessment** | | | |
| **Goals of Care**:  Is an Advance Care Plan/Directive in place?  Yes  No. Is the client for  no CPR  no ICU.  Please list other Goals of Care and attach any documentation available | | | |
| Allergies | | | MRO or infectious disease |
| Medications: Medication list: Current medication list attached  OR complete list below   |  |  | | --- | --- | |  |  | |  |  | |  |  | |  |  |   Patient has a prescription or adequate medication supplies for 5 days  Yes  No  **Note:** patient may not be reviewed by a doctor/nurse practitioner for up to 7 days. | | | |

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| **Current treatments, therapies and devices (tick for yes)**  Subcutaneous infusion Urinary Catheter - date last changed: Click or tap to enter a date.  Wound (for complex wounds, include copy of current wound care plan) Stoma (type):       Feeding tube  Yes  No  **Central Venous Access Device**  External Length       (to check for dislodgement) Site:  Date last flushed: Click or tap to enter a date. Date last dressed: Click or tap to enter a date.  **Drain Site** (can be multiple)   |  |  |  |  | | --- | --- | --- | --- | | Type |  | Frequency of drainage: |  | | Type |  | Frequency of drainage: |  |   Chemotherapy - (for cytotoxic precautions) Date last given: Click or tap to enter a date.  Radiotherapy - (for pain and skin care) Date of last treatment: Click or tap to enter a date.  Other treatments: | | | | | | | |
| Referred by: |  | | | Designation | |  | |
| Email: |  | | | Phone No: | |  | |
| Fax No: |  | | | Date: | |  | |
| Referral Source: |  | | | (Ward/dept/centre) | |  | |
| Doctor Authorising referral: |  | | | Specialty (inpatients) | |  | |
| GP Name: |  | Phone No: |  | | Fax: | |  |
| GP After Hours available  Yes  No | | | | Phone No: | |  | |