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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 [ ]  NoHave end of life discussions occurred and is the patient/family aware of this referral? [ ]  Yes [ ]  NoIs 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 [ ]

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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)

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| 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: |       |