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

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

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| Does client have an active, progressive, terminal illness requiring symptom management? [ ]  Yes [ ]  NoIs the client aware of the referral? [ ]  Yes [ ]  N |
| Diagnosis: |       |
|       |
|       |
| **Summary of reason for referral. (Attach recent letters/scans/ blood results or Discharge Summary, and if available, PCOC assessment, Ambulance Care Plan and Advanced Care Plan** |
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| Allergies | MRO |

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| MEDICATIONSNote: Client may not be reviewed by a doctor for up to 7 days, so please ensure that the client has a medication list, and prescription or adequate medication supplies.  |

*Note: oxygen must be ordered by a specialist prior to discharge.*

**INJECTABLE MEDICATION CHART:** I authorise Silver Chain Registered Nurses to administer the following medications if required: (e.g., analgesia, antiemetic and sedation).

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| **Drug Name** | **Dose** | **Freq** | **Route** | **Doctor Signature** | **Doctor Name** | **Date** |
|       |       |       |       |       |       |       |
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| Current Treatments[ ] Chemotherapy (details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Given: \_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Radiotherapy (details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  PICC Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Flushed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Dressed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Port Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Flushed: \_\_\_\_\_\_\_\_\_\_\_ Date Last Dressed: \_\_\_\_\_\_\_\_\_[ ]  Drain Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency of drainage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Urinary Catheter [ ]  Nephrostomy Date Last Changed:       [ ]  Wound (for complex wounds please fax copy of current wound care plan) |
| Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Ward/Dept/Centre)Referral Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: GP After Hours available Yes / No Phone No:  |