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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  No  Is the client aware of the referral?  Yes  N | | |
| Diagnosis: |  | |
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| **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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| MEDICATIONS Note: 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: | | | | | | | |