# ALL NEW REFERRALS MUST BE FROM A MEDICAL PRACTITIONER OR A NURSE PRACTITIONER WORKING IN PALLIATIVE CARE

**If a visit is required within 24 hours, phone and request to speak with Palliative CNCM for verbal handover.**

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| **TELEPHONE (08) 9242 0242** | Facsimile 1300 601 788 |

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| **CLIENT NAME AND ADDRESS (PLEASE USE LABEL IF AVAILABLE)** |
| \*Surname:       | \*Title:       |
| \*Forename/s:       | \*Date of Birth:       |
| \*Address:       |
| \*Home Phone:       | Mobile Number:       |
| Email:       |
| Name of Next of Kin:       | Phone Contact:       |

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| **\*Does client have an active, progressive, terminal illness requiring symptom management? [ ]  Yes [ ]  No** |
| **Has the client (or their proxy) agreed to the transition from active management to palliative care?****Y\_\_\_\_\_\_N\_\_\_\_\_\_****If No Please discuss prior to submitting this referral.****Please include any ACP/AHds with the referral.** |
| Diagnosis:       DateofDiagnosis:       Metastases(location):        |
| **Referred by Doctor/Palliative Nurse Practitioner**\*Name       \*Signature \*Date       Phone No:       Is this referral from a GP? [ ]  Yes GP Details--------------------------------- Phone number---------------**Hospital Referrals:** Hospital:       Ward:       Palliative Team involvement--Name Facility Phone  |
| MEDICATIONS**Client may not be reviewed by a doctor for up to 7 days,** *ensure that the client has a medication list and adequate medication supplies.* | **Allergies:**      **MICRO ALERT:**       |

**OXYGEN:** Must be ordered by a specialist prior to discharge: Complete Oxygen referral form or contact DVA.

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

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| **Medication Name** | **Dose** | **Freq** | **Route** | **Doctor Signature** | **Doctor Name** | **Date** |
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| \*Surname       \*Forename/s        |

**Summary of reason for referral/update including psychosocial. Please also send recent letters/scans/ blood results or Hospital Discharge Summary. Palliative care services: please include most recent Symptom Assessment Scores and Australian-Modified Karnofsky Scale Score (if used).**

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| Current Treatments**Name of Chemotherapy**       Date Last Given:       [ ]  Radiotherapy [ ]  Site       [ ]  Other Treatments        |
| [ ]  PICC Type       Length:      Date Last Flushed:        Date Last Dressed:       [ ]  Port /type      Date Last Flushed:       Dressing:       [ ]  Rocket Drain [ ]  Pleural [ ]  Abdominal- Drainage instructions--------------------------------------------[ ]  Urinary Catheter [ ]  Nephrostomy Date Last Changed:       [ ]  Wound ( please fax copy of current wound care plan)[ ]  Pressure Injury-----Stage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Falls Risk[ ] Equipment Required?\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **RN Name:** **Signature:** **Date:**  |