# 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.**

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

|  |  |
| --- | --- |
| **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: |

|  |  |
| --- | --- |
| **\*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).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Freq** | **Route** | **Doctor Signature** | **Doctor Name** | **Date** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |
| --- |
| \*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).**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| 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:** |