Confidential Referral Cover Sheet

Please acknowledge that you have received this referral by completing and signing below and returning via fax/email/mail

Date Sent: dd/mm/yyyy / /	**Consumer**
	Name:
	Date of Birth: dd/mm/yyyy / /
Number of Pages (including cover sheet):	Sex:
	UR Number:
	or affix label here

Referral to

Name: IP ACCESS UNIT @ PJC

Position: PALLIATIVE CARE UNIT

Organisation: WANTIRNA HEALTH

Phone: 988|1807

Fax: 9881 1886

Email address: *IPAccessPJC@easternhealth.org.au

Address: Cnr Mahoneys Rd & Burwood Highway, Burwood East

Agency/Service Provider sending referral

Name:

Position:

Organisation:

Phone:

Fax:

Email address:

Address:

Priority

This referral is:	☐ Low	☐ Routine	☐ Urgent	☐ Renewal (ACAS)
	hold over during peak demand	*attend in date order (this may include the consumer being placed on a waiting list)*	*cannot wait*	*For ACAS Assessment*

List of Attachments: **(please tick relevant box(es))**

Consumer Information (required)	Summary and Referral (required)	
☐ Service Coordination Plan	☐ Living Arrangements Profile	☐ Consumer Consent
☐ Health Conditions Profile	☐ Psychosocial Profile	☐ Functional Profile
☐ Functional Assessment Summary	☐ Other:	☐ Health Behaviours Profile

Other notes:

Referral Acknowledgement

Please be advised that the above referral has been received and: *(Please tick appropriate box)*

☐ **The referral is accepted**. Estimated date of consumer assessment dd/mm/yyyy / /

or

☐ **The referral is not proceeding** for the following reason(s):

☐ Consumer declining	☐ Waiting list time inappropriate for consumer	☐ Ineligible for services	☐ Inappropriate referral	☐ Other

If referral not proceeding provide additional comments below.

Comments and any further actions undertaken:

Date Acknowledged: dd/mm/yyyy / / Name: Position:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 1 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Referral

Referral Type (*check one only*):

- ☐ 1 To Community based service
- ☐ 2 To inpatient service, for admission ASAP
- ☐ 3 To inpatient service, for respite
- ☐ 4 Backup info only, not seeking admission at present

ECOG Status (*check one only*):

- ☐ 0 Fully active, full pre-disease performance
- ☐ 1 Ambulatory, capable of light house/office work
- ☐ 2 Ambulatory, cannot work but can self-care
- ☐ 3 In bed or chair over 50% of time, limited self-care
- ☐ 4 Confined to bed or chair, can't self-care

Is the Client an Inpatient? ☐ Yes ☐ No **Ward / Clinic:**

Reason for Admission: Expected discharge date:

Consultant: **Contact:**

Medical History

Diagnosis (*inc. histology if applicable*): Date of diagnosis:

Additional Medical History (*to supplement information in Summary & Referral form - include stage of disease, results of recent investigations, symptom control issues, summary treatment history, e.g. chemotherapy, radiotherapy, surgery, transfusions, etc, and relevant past medical history*):

This form completed by:

Name: Position / Agency:

Date: Contact number:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 3 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Living Arrangements and Psychosocial Issues

Living Arrangements: ☐ 1 Lives alone ☐ 2 Lives with carer ☐ 3 Lives in supported accommodation	
Social Support (*comment on personal and social support, including social isolation and family and personal relationships*):	
Is the client aware of the diagnosis and prognosis? ☐ Yes ☐ No If not, why? Is the family aware of the diagnosis and prognosis? ☐ Yes ☐ No If not, why? Has a family meeting been held? ☐ Yes ☐ No If yes: ☐ Inpatient setting ☐ Community setting Date:	
Psychosocial Issues (*e.g. family & personal relationships, previous losses, family problems, concurrent life crises*):	
Cultural considerations:	
Challenging Behaviours: Does the person have behavioural problems, for example aggression, wandering or agitation?	☐ Yes ☐ No Details:
Cognition: Does the person have memory problems or get confused?	☐ Yes ☐ No Details:
Religion: Parish:	Spiritual screening attended? ☐ Yes ☐ No Pastoral care contact:

Multidisciplinary Assessments

Have any relevant assessments been carried out (e.g. Aged Care, Physiotherapy, OT, Social Work, Volunteer or other)? Please list type of assessment, and contact details of assessing practitioner. Please include or attach assessment summaries.

Assessment	Assessor Name and Phone Number	Notes
Aged Care		

Other Information

This form completed by:

Name: Position / Agency:

Date: Contact number:

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 2 of 3.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Treatment

Key Symptom Issues: ☐ Pain ☐ Nausea ☐ Anorexia ☐ Constipation ☐ Diarrhoea ☐ Breathlessness ☐ Anxiety ☐ Fatigue Other:

Current Treatment (*including chemotherapy regimens / radiotherapy plans if applicable - see Summary & Referral form for medications*):

Advance Care Plans (*client understanding of pall. care, and discussions re NFR, antibiotics, transfusions, radiotherapy*):

Nursing Care

Personal Care: Does the client have difficulty or need assistance with dressing or grooming, bathing or showering, or other personal care?	☐ Yes ☐ No Details:
Continence: Does the client require continence management, e.g. IDS, pads?	☐ Yes ☐ No Details:
Mobility: Does the client have difficulty or need assistance with mobility, e.g. walking or moving around the house? Do they need or have any aids, e.g. a wheelchair?	☐ Yes ☐ No Details:
Falls Risk:	

Nursing Issues (*e.g. peg feed, nasogastric tube in situ, tracheostomy, home oxygen*):

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Consumer details

Family Name:

Given Names:

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? _____ Code: ☐

Preferred Name/s:

Sex: _____ Code: ☐ **Title:** _____

Contact Address (*for correspondence, home visits etc.*)

Usual Address (if different from contact address)

Contact phone number/s *(check preferred number)*

Can leave message?

☐ Home: ( ) ☐ Yes ☐ No

☐ Work: ( ) ☐ Yes ☐ No

☐ Mobile: ☐ Yes ☐ No

☐ Email: ☐ Yes ☐ No

Country of Birth: _____ Code: ☐

Indigenous Status: _____ Code: ☐

Need for Interpreter Services: _____ Code: ☐

Preferred Language: _____ Code: ☐

Communication Method: _____ Code: ☐

General Practitioner *(if no GP, write NA)*

Name:

Address:

Phone:

Fax:

Email:

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name:

Contact Address

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: Code: ☐

Is this person the consumer's carer? Code: ☐

Person 2 Name:

Address:

Phone:

Government Pension/Benefit Status: _____ Code: ☐

Health Care Card Holder Status: Code: ☐

Card number:

Medicare Card:

Card number:

Health Insurance Status:

Insurer name:

Card number:

DVA Card Entitlement:

DVA card type: Code: ☐

DVA card number:

Compensables Funding Source: _____ Code: ☐

Comments:

Consumer Information

Produced by the Victorian Department of Human Services, 2006

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number: