HammondCare

SPECIALIST PALLIATIVE & SUPPORTIVE CARE SERVICE REFERRAL FORM NORTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Referral to : ☐ PALLIATIVE CARE INPATIENT UNIT ☐ COMMUNITY PALLIATIVE CARE SERVICE

ATTENTION: ☐ Dr Bridget Johnson (Greenwich) ☐ Dr Sarah Thompson (Neringah)
☐ Dr Phil Macaulay (Northern Beaches)

Referrer`s Name : _____

Referrer's contact no: _____

Referral`s Facility: _____

On behalf of Dr: _____

Dr`s Provider no: _____

GP name (if not referring doctor): _____

Practice name: _____

GP Phone no: _____

Is GP aware of referral? ☐ Yes ☐ No

Patient location: _____

Consent to referral? ☐ Patient ☐ Family

Person responsible: _____

Relationship: _____ Phone no: _____

Name of palliative care consultant: _____

Medicare no: _____

Health fund name: _____ No: _____

Language: _____ Lives alone? ☐ Yes ☐ No

Interpreter needed? ☐ Yes ☐ No

Reason for referral (select one or more if appicable):
☐ Symptom control ☐ Terminal care ☐ Psychosocial support ☐ Supportive care

Diagnosis and treatment (previous & current):

Medical history:

NSW Health Resuscitation Plan completed? (Please attach to this form) ☐ Yes ☐ No

Relevant additional documents not available on eMR attached ☐ Yes ☐ No ☐ N/A

Infection status and location:

Special instructions (tracheostomy, wound care, CVADs, PEG, modified diet needs):

Falls risk / behavioural concerns:

☐ Functional status: ☐ Independent ☐ Partial assist ☐ Full assist

Skin integrity: Waterlow score:

Patient and family concerns: _____

Understanding of disease: _____

Goals of care: _____

Spiritual / cultural needs : _____

Referring doctor's signature:

Date:

PLEASE FAX COMPLETED REFERRAL TO:

Greenwich Hospital Inpatient Unit Ph: 9903 8227 Fax: 9903 8100

Neringah Hospital Inpatient Unit Ph: 9488 2200 Fax: 9487 1599

Palliative Care Community North : Ph: 1800 427 255 Fax: 9903 8265

(For urgent referrals please phone the relevant number above)