HammondCare
Champion Life

BREASIDE HOSPITAL
PALLIATIVE CARE REFERRAL FORM

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

Date of Referral: _____

Planned Admission Date: _____

Referral Received by: _____

MRN: _____

Referral Source

Community Centre		***Hospital***	
Prairiewood	☐	Liverpool	☐
Hoxton Park	☐	Fairfield	☐
Bankstown	☐	Bankstown	☐
Other	☐	Other	☐

Surname: Middle name: First name

D.O.B Age: Gender: Male ☐ Female ☐

Social situation:

Diagnosis:

PMHx:

Reason for Admission: ☐ Symptom Control ☐ Terminal Care ☐ Other

☐ Single room required ☐ Contact precautions ☐ Dying ☐ Other

Issues at Referral:

Goals/ Limits of Care:

Medication chart faxed to Braeside Pharmacy Fax no: 9756 8954 ☐ Yes ☐ No

Contact Person: Pager No / Contact No:

Palliative care consultant involved: Ward location:

Limited Access Current Medications (eg SAS meds, anti-rejection meds**)**

	Drug Name	**Drug Route**	**Drug Dose**
1			
2			
3			

Pressure Area / Drains / Wounds

Location: _____

Infection Risk: _____

Falls Alert: _____

Swallowing Alerts: _____

Behavioural Alert: _____

Other Alerts: _____

Bed Bound **Yes** ☐ **No** ☐

Level of Mobility: _____

Waterlow Score: _____

Rug Score: _____

Outcome:

Cancelled Date:

BINDING MARGIN NO WRITING

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