HammondCare Champion Life

SPECIALIST PALLIATIVE CARE INPATIENT REFERRAL FORM NORTH

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

Please send completed *INPATIENT* Referrals to:

Greenwich NUM: (Ph) 0400 788 807 (E) greenwichpcu@hammond.com.au

Neringah NUM: (Ph) 0438 891 359 (E) neringahpcu@hammond.com.au

Patient Details: Referral advised to and consented by ☐ Patient ☐ Family

Patient location/Hospital: _____

Language Spoken: _____ Is interpreter needed? ☐ Yes ☐ No

Person responsible: _____ Relationship: _____

Phone no: _____ Mobile: _____

Referrer Details

Referrer`s Name : _____ Provider number: _____

Referral`s Facility: _____

Phone no: _____ Fax no: _____

Diagnosis and treatment *(previous & current)*: _____

_____

_____

_____

_____

Reason for Referral *(select one or more if applicable):*

☐ End of Life Care ☐ Symptom Management ☐ Psychosocial Support

Please Indicate documents sent with this referral:

☐ Discharge Summary ☐ Investigations ☐ Current Care Plan/ Goals of care

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

BINDING MARGIN NO WRITING

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Falls risk / behavioural concerns: _____

_____

_____

Infection status and location: _____

_____

_____

_____

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

_____

_____

_____

_____

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

Skin integrity: **Waterlow score:**

Patient and family concerns:

_____

_____

_____

_____

_____

Understanding of disease:

_____

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Goals of care:

_____

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Spiritual / cultural needs:

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_____

_____s_____

Referrer Signature:

Date:

BINDING MARGIN NO WRITING

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