HammondCare Champion Life

SPECIALIST PALLIATIVE CARE COMMUNITY REFERRAL FORM NORTH

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

Community Palliative Care Services

☐ Dr Victor Sze (Greenwich Community)

☐ Dr Wei Lee (Neringah Community)

☐ Dr Phil Macauley (Northern Beaches Community)

Please fax or email completed community referral with attachment to:

(For urgent referrals please phone 1800 427 255)

Greenwich Palliative Community Services : (Fax): 9903 8265
Email: gcteam@hammond.com.au

Neringah Palliative Community Services: (Fax): 9488 2247
Email: ncteam@hammond.com.au

Northern Beaches Palliative Community Services: (Fax) 1800 426 347
Email: nbpcsadministration@hammond.com.au

Specialist Community Palliative Care Eligibility Criteria (Please tick all that apply):

☐ The patient's primary residence is in the geographical area of Northern Sydney Local Health District
and
☐ The patient is over the age of 18
(Palliative Care may be provided in collaboration with Paediatric Palliative Care service after discussion)
and
☐ The patient has progressive life limiting or life-threatening illness (malignant and/or non-malignant)
and
☐ the patient and/or substitute decision maker consents to referral to the service
and

<u>one or more</u> of the additional criteria below:

☐ The patient has complex symptoms related to their diagnosis that require specialist assessment and management
☐ The patient and/or family has complex emotional, psychosocial or spiritual needs related to the life-limiting diagnosis and impacting on care in the community that require specialist multidisciplinary team (MDT) assessment and management
☐ The primary care team and/or patient and care givers would benefit from support when undertaking complex future care planning
☐ It would not be a surprise if the patient died in the next 12 months and the primary care team requires additional support and /or advice in addressing complex needs

Alternative Service Providers:

Patients who are referred with unmet needs that are more appropriately managed by disease specific supportive care models and/or aged care services may fall outside the scope of our service, unless the patient is thought to be in the final 6 months of life

Discharge from Service:

If patients no longer have specialist needs, move out of area, decline further input, or are more appropriately serviced by alternative providers, they will be discharged from service. Providers and patients will be notified, and re-referrals are welcomed, should the situation change in the future.

Please ensure the relevant palliative care team is copied on all specialist correspondence and imaging results to ensure contemporaneous information is available when reviews are undertaken.

BINDING MARGIN NO WRITING

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Please attach most recent specialist correspondence, imaging and pathology with this referral.

NOTE: incomplete referrals may result in delay to commencement of service

Patient Demographics:

Religion: …… Country of Birth: ……

Preferred Language: …… Interpreter ☐ Yes ☐ No

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & TSI ☐ Neither ☐ Prefer not to disclose

Contact Details: H: …… M:…… Email: ……

Medicare No: …… Health Fund Name: …… Health Fund Number: ……

DVA Number: …… DVA Card Colour: ……

Person responsible: …… Relationship:…… Phone no: ……

Does the patient live alone? ☐ Yes ☐ No Consent to referral? ☐ Patient ☐ Carer

Reason for Referral:

☐ Complex symptom control ☐ End of Life Care at Home ☐ Carer needs related to terminal diagnosis ☐ Early Palliative Link

Diagnosis:

Current Treatment:

Estimated Prognosis:	☐ Days ☐ Weeks ☐ <6 Months ☐ >6 Months
Other Significant Medical Issues or attach document):	
Current Medications (or attach document):	
Allergies:	

Service Providers:

GP …… Phone: ……Aware of referral? ☐ Yes ☐ No

Specialist …… Location: ……

Specialist …… Location: ……

Other providers e.g. NDIS/Community nursing/Aged Care: ……

Advance Care Planning:

Has the patient's Resuscitation Status been discussed? ☐ Yes ☐ No

Advance Care Directive/Plan? ☐ Yes ☐ No ☐ Unknown (If answered yes, please attach copy)

Enduring Power of Attorney/Enduring Guardian? ☐ Yes ☐ No ☐ Unknown. If yes, who?……

Please describe the patient's insight into their disease/preferred goals of care: ……

……

Functional Status: ☐ Independent ☐ Partial Assist ☐ Full Assist

Psychosocial/Spiritual Issues:

Known to Social worker/Psychologist/Psychiatrist? ☐ Yes ☐ No (if answered yes, please provide detail below)

Details: ……

Identified Risks to Staff? ☐ Yes ☐ No Details:……

Referrer Details:

Name: …… Designation: ……

Organisation: …… Provider Number: ……

Phone: …… Fax: …… Email: ……

Sign: …… Date: ……/……/……

BINDING MARGIN NO WRITING

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