HammondCare Champion Life

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**

ATTENTION: ☐ Dr Eunice Ho (Greenwich)

☐ Dr Sarah Thompson (Neringah)

☐ ***COMMUNITY*** **Palliative Care Service**

☐ Dr Victor Sze (Greenwich Community)

☐ Dr Shawna Koh (Neringah Community)

☐ Dr Philip Macaulay (Northern Beaches)

Please fax Completed *INPATIENT* Referrals to:

Greenwich NUM: (Ph) 0400 788 807 (Fax) 9903 8100

Neringah NUM: (Ph) 0438 891 359 (Fax) 9487 1599

For urgent referrals please phone the relevant number above and follow the prompt.

Please fax or email Completed *COMMUNITY* Referrals to:

Greenwich Hospital: (Fax): 9903 8265
Email: gcteam@hammond.com.au

Neringah Hospital (Fax): 9488 2247
Email: ncteam@hammond.com.au

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

(For urgent referrals please phone 1800 427 255)

Referrer Details: ☐ Specialist ☐ GP

Referrer`s Name : _____ Contact no: _____

Referral`s Facility/Practice : _____

Provider no: _____ Fax no: _____

Is patient GP aware of referral? ☐ Yes ☐ No ☐ N/A

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

☐ Symptom control ☐ Terminal care ☐ Psychosocial support ☐ Supportive care ☐ Breathlessness program

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

Patient location/Hospital: _____

Medicare no: _____ Health fund name: _____ Fund no: _____

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

Person responsible: _____ Relationship: _____ Phone no: _____

Name of palliative care consultant: _____ Lives alone? ☐ Yes ☐ No

Diagnosis and treatment (previous & current):

Indicate documents attached or fax with Referral

☐ Discharge Summary ☐ Medications Authority ☐ Investigations ☐ Management of Care plans

BINDING MARGIN NO WRITING

SPECIALIST PALLIATIVE & SUPPORTIVE CARE SERVICE REFERRAL FORM

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FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
DOB	M.O	
ADDRESS	*Version: August 2019*	
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

PCOC Phase: RUG: AKPS: SAS:

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

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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_____

_____

Dr Signature: **Date:**