# 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:**

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)*: ______________________________

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**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:** ______________________________

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**Infection status and location:** ______________________________

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

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

**Skin integrity:** **Waterlow score:**

**Patient and family concerns:**

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**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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