Palliative Care Home Support Program

Package Referral Form V7

To be completed by an approved palliative care referrer and faxed to 1300 882 807 or emailed to pchsp@hammond.com.au

Patient Details

Primary Diagnosis ………………………………………………………… MRN ………………………………

Patient Full Name ………………………………………………………… Date of Birth ………………………………

Patient Preferred Name ………………………………………………… Gender ………………………………

Address

………

Is the patient in a nursing home? No ☐ Yes ☐

Facility Manager Name ……………………………………………… Phone ………………………………

GP Name ………………………………………………………………… Phone ………………………………

Preferred Hours of Care (e.g. 20:00 – 06:00) ……………………………… Start Date ………………………………

Frequency of Care (e.g. daily, weekly etc.) ……………………………………………………………………

Number of Care workers …………… Female ☐ Male ☐ No Preference ☐

Language Spoken at Home: ……………………………………………………

Is Language/Communication Assistance/ CALD worker required? No ☐ Yes ☐ (please specify)

………

Indigenous Status Aboriginal ☐ Torres Strait Islander ☐ Neither ☐

Cultural/Spiritual Needs ……………………………………………………………………………………………

Parking available at patient's home/access details/directions ………………………………………………

………

Home Risk Assessment Undertaken? **Must be completed in person prior to services being organised.**

No ☐ Yes ☐ Risks Detected ……………………………………………………………………………

Family/Carer Details

Does the patient have a carer? No ☐ Yes ☐ Gender ………………………………

Is the carer able to assist with physical care? No ☐ Yes ☐

Name ……………………………………………………… Relationship to Patient ………………………………

Address (if different to patient) ……………………………………………………………………………………

Home Phone ……………………………………………… Mobile Phone ………………………………

Alternative Contact Name ………………………………… Alternate Phone ………………………………

Description of Assistance (Provided by care worker)

☐ Respite			
☐ Personal Care	☐ Bed sponge ☐ Continence management ☐ Manual Handling ☐ Shower assistance ☐ Pressure area care ☐ Mobility	☐ Comfort care ☐ Eye care ☐ Oral care	Aids: ☐ Hospital bed ☐ Walker ☐ Slide sheet ☐ Lifter ☐ Wheel chair ☐ Shower Chair ☐ Commode
☐ Domestic Assistance			

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Eligibility Criteria:

1. ☐ Patient has expressed a wish to remain at home for as long as possible; **AND**
2. ☐ Their palliative care phase is either deteriorating or terminal (see box below); **AND**
3. ***One or more of the following are present (please tick all that apply):***
   - ☐ Family carer is physically/emotionally unable to continue caring at home without support
   - ☐ There is limited family support
   - ☐ There are specific cultural/spiritual issues necessitating extra support
   - ☐ Carer stress is high
   - ☐ Functional ability of patient is poor

Palliative Care Phase (Please tick one as appropriate)		
Deteriorating	There is a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.	☐
Terminal	Death is likely in a matter of days and no acute intervention is planned or required	☐

Patient Summary for Care Worker Handover - Current Diagnosis/Relevant medical History/Social issues and other relevant Information.

If the patient dies or there are any changes to services, please contact PCHSP on 1300 884 304 or email pchsp@hammond.com.au. Hours of operation are 06:00-23:00, 7 days a week including public holidays. Outside operating hours, please leave voicemail or send email.

Referrer Details

Date of Referral .... Referrer Name ………..........................……....……….

Referrer LHD ………... Referrer Phone ………..........................…........….. ……...

Nurse coordinating ongoing care …………..…….........................……..........................

Business Hours Phone .... After Hours Phone ………...........................…...……….

This Referral has been discussed with the patient/carer who has provided consent: Yes ☐ No ☐

Is it likely this patient would require admission to hospital or remain in inpatient care if it were not for the Palliative Care Home Support Package? Yes ☐ No ☐

Referrer Signature .... Position .... Date ....