

Palliative Care Clinical Referral

South East Palliative Care

140 – 154 Sladen Street

Cranbourne VIC 3977

Telephone: (03) 5991 1300 Fax: (03) 5991 1301

Client	or affix label here
Name:	
Date of Birth: / /	Sex:
Address:	
Phone Number:	

Referral

Referral Type <input type="checkbox"/> 1 Standard (response expected within 24-48 hrs) <input type="checkbox"/> 2 URGENT, cannot wait (phone service to discuss)	ECOG Status (<i>check one only</i>): <input type="checkbox"/> 0 Fully active, full pre-disease performance <input type="checkbox"/> 1 Ambulatory, capable of light house/office work <input type="checkbox"/> 2 Ambulatory, cannot work but can self-care <input type="checkbox"/> 3 In bed or chair over 50% of time, limited self-care <input type="checkbox"/> 4 Confined to bed or chair, can't self-care
Reason for Referral:	

Is the Client an Inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ward / Clinic:
Reason for Admission:	Expected discharge: / /
Consultant Name:	Contact Number:
General Practitioner Name:	Contact Number:

Medical History

Diagnosis (<i>inc. histology if applicable</i>):	Date of diagnosis:	/ /
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language:	
Current Medical History (<i>including stage of disease, results of recent investigations, symptom control issues, and summary treatment history, e.g. chemotherapy, radiotherapy, surgery, transfusions, etc</i>):		
Key Symptom Issues: <input type="checkbox"/> Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Breathlessness <input type="checkbox"/> Anxiety <input type="checkbox"/> Fatigue Other:		
Relevant Past Medical History:		

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Treatment

Current Treatment (including chemotherapy regimens / radiotherapy plans if applicable):			
Medications (list medications at time of referral):			
Known Allergies:			
Advanced Care Plans (client understanding of pall. care, and discussions re NFR, antibiotics, transfusions, radiotherapy):			

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Nursing Care

Personal Care: Does the client have difficulty or need assistance with dressing or grooming, bathing or showering, or other personal care?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Contenance: Does the client require continence management, e.g. IDC, pads?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Mobility: Does the client have difficulty or need assistance with mobility, e.g. walking or moving around the house? Do they need or have any aids, e.g. a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Falls Risk:	
Nursing Issues (e.g. peg feed, nasogastric tube in situ, tracheostomy, home oxygen):	

