**Palliative Community Supportive Care Services Referral Form**

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| **Clinic referred to:**  **Palliative Community Supportive Care Services Referral Form** | | **Dear Dr……………………………………………………..** | | |
| **Date of Referral:** | | |
| **Referrer Details** | | | | |
| Name | | Designation | | |
| Organisation | | Provider number | | |
| Contact phone | | Contact Fax/Email | | |
| **Patient Details** | | | | |
| Surname: | Given name: | | Gender: | DOB: |
| Address: | | | | MRN: |
| Home Ph: | Mobile: | | Email: | |
| Medicare No: | | | | |
| Country of Birth: | Preferred Language: | | Interpreter? Y  N | |
| **Next of Kin/Carer** | | | | |
| Who to contact regarding this referral? Patient  Other  Contact details: | | | | |
| Is the patient aware of the referral? Y  N | | Is the carer aware of the referral? Y  N | | |
| **Service Providers** | | | | |
| GP Name: | | GP Phone: | | |
| Specialists:  Specialist Phone: | | | | |
| Community Nursing Services: Y ☐ N ☐ | | NDIS: Y ☐ N ☐ | | |
| **Clinical details** | | | | |
| **Life-limiting illness diagnosis:** | | **Allergies:** | | |
| **☐ Attached copy of medical history** | | **☐Attached copy of current medication** | | |
| **Reason For Referral:** | | | | |
| Complex Symptom Control | | Y ☐ N ☐ | | |
| If yes, please outline details of complex and/or persistent symptoms requiring treatment | | | | |
| Advance Care Planning  (Attach copy of any relevant documents) | | Y ☐ N ☐ | | |
| Other (please outline) | | | | |
| **Multidisciplinary Team Needs?** Y ☐ N ☐ | | | | |
| Social Worker | | Psychologist | | |
| Occupational Therapist | | Physiotherapist | | |
| Dietitian | | Speech Pathologist | | |
| Aboriginal Liaison Officer | | Pharmacist | | |

Fax referrals to Palliative Community Supportive Care Clinic Office: 9382 0422

If you would like to discuss the referral please contact Palliative Community Supportive Care Clinic: 9382 0400