SESLHD GUIDELINE COVER SHEET

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AUTHORS	SESLHD Palliative Care Policy Working Party
POSITION RESPONSIBLE FOR DOCUMENT	SESLHD Palliative Care Clinical Services Manager Kim.Rigg@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Cancer and Palliative Care Services
KEY TERMS	Palliative Care
SUMMARY	This document describes the referral criteria for staff to understand when a referral to obtain palliative care advice and support is appropriate.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Referral to Palliative Care

Section 1 – Background

To achieve safe and high-quality Palliative Care including end of life care, systems and processes to support clinicians need to be in place.

Health service organisations with a specialist Palliative Care service need to develop formal referral guidelines and processes so staff understand when to access advice from a Specialist Palliative Care clinician[2].

This guideline aims to provide information for staff on:

1. Palliative Care definitions
2. Responsibilities of staff
3. The referral criteria to obtain Palliative Care advice and support
4. Inpatient and Outpatient referral processes
5. Documentation requirements

Section 2 - Definitions

- **Palliative Care:**
  - Palliative Care is more than only end-of-life care and physical symptom management. Palliative Care helps people live their lives to the fullest when living with a life-limiting or terminal illness. It is person-centred care that considers the individual's physical, emotional, social and spiritual needs, as well as the needs of their loved ones and carers. It also empowers patients and their loved ones to make decisions about their future care through Advance Care Planning.

- **Palliative Care Providers:**
  - All clinical staff are responsible for providing clinical management and care coordination using a palliative approach for the person with uncomplicated needs associated with a life limiting illness and/or end of life care.
  - Specialist Palliative Care offers support for patients with complex Palliative Care needs. 'Complex needs' are those physical, psychosocial or spiritual needs that are not responding to the basic palliative approach. Patients and/or families may have needs across multiple domains. Needs are patient-centred, not diagnosis dependent.

- **Palliative Care Services:**
  - **Inpatient**
    i. Palliative Care Unit: Inpatient Palliative Care Units (sometimes called 'hospices') are designed to support Palliative Care patients with complex needs once care at home is no longer possible. Patients are admitted under a Specialist Palliative Care doctor and receive care from a multidisciplinary team for their physical and psychosocial/spiritual wellbeing.
    ii. Consultative: Patients admitted under non-Palliative Care teams in an acute hospital can receive Specialist Palliative Care support and advice from Palliative Care Consultative Teams. These patients are often receiving contemporaneous treatments from their primary care teams.

  - **Outpatient**
    i. Clinic: Ambulatory patients with complex Palliative Care needs can be seen in outpatient clinics by a Palliative Care Specialist doctor or nurse.
    ii. Community: Patients at home who require the support of the Palliative multidisciplinary team (MDT) or who are unable to attend an outpatient clinic can receive Palliative Care support at home or in their Residential Aged Care Facility (RACF).

Section 3 - Responsibilities

Nursing and Allied Health

Nursing and allied health staff can identify patients who are appropriate for referral to the specialist Palliative Care service. They work as part of a multidisciplinary approach to improve outcomes for patients with life limiting illness.

Medical team

The treating medical team is responsible for the identification of patients appropriate for involvement of Palliative Care. The team should provide basic management of common symptoms and collaborate with Specialist Palliative Care services when basic management is insufficient. The team should initiate patient-centred discussions about future care planning including provision of prognostic information and the role of Palliative Care.

Section 4 - Criteria for Referral

- The patient has progressive life limiting or life threatening disease (malignant and/or non-malignant)

  and one or more of the additional criteria below:

- The patient has complex symptoms that require specialist assessment/management
- The patient and/or family has complex emotional, social or spiritual needs that require specialist assessment
- The primary care team and/or patient and family would benefit from support when planning for, or undertaking withdrawal of life prolonging treatment
- It would not be a surprise if the patient died in the next 12 months and support is needed for advance care planning discussions
- The patient is dying and the primary care team requires additional support and /or advice.

In cases where the patient meets the above criteria for referral, they may also be appropriate for review in order to:

- Facilitate a link to the local Community Palliative Care Team (CPCT) **or**
- Discuss appropriateness of transfer to a Palliative Care inpatient Unit.

Section 5 - Referral Process

Information to be included by the referrer:

- The patient and their family/care giver is aware of the referral
- The palliative diagnosis
- Current treatment and future treatment planned
- Other relevant diagnoses and criteria for referral
- Other relevant pathology and imaging results if not available on eMR
- Names of relevant specialists and GP
- Patient/family or carer request
- If appropriate, expected prognosis and current Advance Care Plan/Advance Care Directive

How to make a referral:

After Hours Urgent Advice for St George Hospital (SGH), The Sutherland Hospital (TSH), Calvary Hospital (CHCK)

- For urgent Palliative Care advice for any patient **after hours**, please contact the Palliative Care Consultant on call via switch at Calvary Health Care Kogarah (CHCK) 95533111

Referral Process for The Sutherland Hospital Consult Service

- The TSH palliative care team is a consultancy service that does not admit patients
- Inpatient referrals are electronically submitted via EMR by the **treating medical team** using the 'Orders ADD' tab
- The treating team must also contact the Palliative care team via the internal paging system (as per 'pop up' screen when completing referral) on pager #541
- The TSH Palliative Care Team offer a 7-day service 0800-1630 hrs (CNS cover only on weekends and public holidays). Referrals on a weekend must still go through the process above and may be directed to speak to the Palliative Care Consultant On Call if required
- For urgent Palliative Care advice **after hours**, please contact the Palliative Care Consultant on call via switch at Calvary Health Care Kogarah (CHCK) 9553 3111

Referral Process for The Sutherland Hospital Outpatient Supportive and Palliative Care Clinics

- Supportive and Palliative Care Clinics are based in the Warriwul building at Sutherland Hospital and in addition to Oncology Palliative Care offer other non-malignant clinics including:
    - Respiratory Supportive Care Clinic
    - Cardiac Supportive Care Clinic

  - Supportive Care MDT Clinic
- Referrals can be made by using The Sutherland Hospital Outpatient Clinic referral form (see **Appendix 8)** or a referral letter and emailing either to:
  - SESLHD-TSH-Outpatients@health.nsw.gov.au
  - SESLHD-TSH-PalliativeCare@health.nsw.gov.au
- Referrals must have a valid medical provider number

Referral Process for St George Hospital Consult Service

- The St George palliative care team is a consultancy service that does not admit patients.
- Inpatient referrals are electronically submitted via eMR by the **referring team** using the 'Orders ADD' tab
- The treating team must also contact the Palliative care team via the internal paging system (as per 'pop up' screen when completing referral) on pager that correlates to patient location.
  - 7A & 7B– pager #266
  - Emergency, ICU, 1W,2S, 3S, 3W, 5S, 5A, 6A and Cancer Care Centre -pager #502
  - 3E, 4S, 5W,6S, 6W, 6B, 7W, 7S- pager #349
- The St George Palliative Care Team offer a weekend service 0800-1630 hrs for patients admitted under medical oncology, radiation oncology and haematology (no public holiday cover). Referrals on a weekend must still go through the process above and pager #266 and may be directed to speak to the Palliative Care Consultant "On-Call" if required.
- For urgent Palliative Care advice **after hours**, please contact the Palliative Care Consultant on call via switch at Calvary Health Care Kogarah (CHCK) 9553 3111

Referral Process for St George Hospital Outpatient Palliative Care clinic.

- Outpatient Palliative Care clinics are located in the Cancer Care Centre at St George Hospital
- Referrals can be made by emailing the referral form (Appendix 1) or a referral letter to SESLHD-StGeorge-CancerCareCentreReferrals@health.nsw.gov.au or if assistance needed call (02) 9113 3943

Referral Process for St George Supportive Care Clinic

- St George Supportive Care Service is located at St George Hospital Level 4, Room 6, Tower Block Building, Gray Street, Kogarah, NSW, 2217. Clinic day is on a Tuesday between 8am-430pm.
- Patients must be 18 years, of age, have a diagnosis of a non-malignant life limiting illness or Glioblastoma Multiforme, must live in the St George area health district, have a GP or specialist referral and require input from medical and at least one other member of the Multidisciplinary team and answer yes to the surprise question for 12 months.

- **Internal referrals** to the Outpatient Supportive Care Clinic are electronically submitted via eMR Powerchart, using the 'Add Order' tab and selecting the respective clinic order type; Supportive Care Service at SGH order type = "Consult SGH Supportive Care Services"
- **External referrals** can be made by completing the St George Supportive care referral form (see **Appendix 7**) and emailing it to SESLHD-StGeorgeSCS@health.nsw.gov.au Please call 91134180 if you need to discuss patients with the Clinical Nurse Consultant.
- All referrals must have a valid medical provider number.

Other St George out-patient clinics for Palliative Care patients with non-malignant diagnoses include:

- Cardiology Supportive Care Clinic via Cardiology Department
- Hepatology Supportive Care Clinic via Hepatology Department
- Respiratory Supportive – Breathlessness Clinic via Respiratory Department
- Renal supportive care clinic via renal department

Referrals can be made through each hospital department's respective outpatient clinics or please contact the CNC for each site for assistance.

St George Private Hospital Palliative care clinic

- Weekly clinic on Level 4 at Southern Oncology in St George Private Hospital 1 Short street, Kogarah.
- Email written referral to admin@sossydney.com.au

Calvary Community Palliative Care Team (CPCT)

- The MDT from Calvary Health Care visits patients who reside in the South Bayside, Georges River and Sutherland Shire LGAs.
- Patients can be referred to the CPCT from their GP, specialist, and primary care team in hospital or via referrals from the consultative team using the CPCT referral form-see **(Appendix 2).** The completed referral form can be emailed to SESLHD-Calvary-CPCT@health.nsw.gov.au or faxed to (02) .95533366 Ensure all relevant information, recent specialist correspondence, pathology, radiology and medication lists are included.
- Use the Calvary Health Care Kogarah Residential Aged Care: Palliative Care Referral Form to consult in a local RACF see **(Appendix 4).**
- For more detailed information regarding the roles and responsibilities within the team, and shared care models review the Calvary Health Care Kogarah Admission and Discharge Criteria Community Palliative Care team (CPCT) see **(Appendix 3)**.
- If a patient lives outside the LGA the consultative team or CPCT can provide information regarding how to link a patient to the appropriate area.

Motor Neurone Disease Service

- All patients with a diagnosis of Motor Neurone Disease in the St George and Sutherland Shires are eligible to be referred to the Calvary Motor Neurone Disease (MND) service.
- The referral could come from any health professional or be self-referred.
- A threshold for entry onto the MND Service is a letter from a Neurologist confirming the diagnosis of MND.
- Referrals are received and triaged by the MND Clinical Nurse Specialist and the MND Social Worker.
- For any referral please contact Calvary Hospital on 95533111 and ask to speak to the MND Clinical Nurse Specialist or the MND Social Worker.

Prince of Wales Hospital (POWH)

POWH Palliative Care service comprises of an Inpatient Consult Service, Outpatient Clinics, the Palliative Supportive Care MDT clinic, Community Palliative Care Team, and Residential Aged Care Team.

For a referral to be made the treating teams need to be aware of, and agreeable to the Palliative Care team's involvement. The patient and their family must also consent to this referral.

Please see information below for how to refer to each service.

Urgent Palliative Care advice after hours

- Please contact the Palliative Care registrar on call via switch at POWH 9382 2222.

POWH Inpatient Palliative Care Consult Service Referrals

- The POWH Palliative Care Team is a consult service that does not admit patients directly. Transfers to an inpatient Palliative Care unit from POWH is arranged via the Palliative Care Consult Team. Both Sacred Heart Health Service and Wolper Jewish Hospital have Palliative Care inpatient beds.
- Internal referrals are electronically submitted via eMR Powerchart, using the 'Add Order' tab and selecting 'Palliative Care Consult Request'. The Palliative Care Registrar should be paged on 44343 or 44286, or via switch.

Outpatient Palliative Care Referrals

POWH has a number of outpatient services including Outpatient clinics, the Palliative Supportive Care MDT Clinic, the Cardiac Supportive Palliative Care Outpatient Service, the Community Palliative Care Team and the Residential Aged Care Facility Palliative Care Service.

How to refer to these services is outlined below:

- Please complete Internal Palliative Care Referral Form for referral from a POWH Specialist (**Appendix 5**) providing supporting information and return by email SESLHD-POWH-PalliativeCare@health.nsw.gov.au. Please indicate on the form if patient is well enough to attend clinic for review.
- Referral from GP or a specialist outside of POWH please use CPCT Referral Form, Please see **(Appendix 6)** return by email SESLHD-POWH-PalliativeCare@health.nsw.gov.au

Palliative Supportive Care Multidisciplinary Clinic

- Please refer by Electronic Referrals Management System (eRMS) or via the Supportive Care Clinic referral form **(Appendix 11)**

Cardiac Supportive Palliative Care Outpatient Service

- Please complete the Cardiac Supportive Care referral form and email to SESLHD-POWCardiacSupportiveCare@health.nsw.gov.au **(Appendix 10)**

Community Palliative Care Team (CPCT)

- POWH internal referral - Please complete the Internal Palliative Care Referral Form **(Appendix 5)**, indicating that a review in their home is preferred and email to: SESLHD-POWH-PalliativeCare@health.nsw.gov.au, or refer via Electronic Referrals Management System (eRMS).
- External referrals from a GP or specialist outside of POWH- Please use the POWH Community Palliative Care Team referral form **(Appendix 6)** and email to SESLHD-POWH-PalliativeCare@health.nsw.gov.au

Residential Aged Care Facility Palliative Care Service

- Please complete the Residential Aged Care Facility Palliative Care Service referral form (**Appendix 9)** and email to SESLHD-nccc-referrals@health.nsw.gov.au.

Section 6 –

Documentation

- All consultations are documented in the electronic medical record
- Advance Care Planning and Goals of Care discussions are documented in the Advance Care Planning Record of Discussion Adhoc eMR tool
- Outpatient Specialist Clinic letters are sent by fax/email to the referring clinicians.

References

- Australian Commission on Safety and Quality in Healthcare End of Life Care: Delivering and Supporting Comprehensive End of Life Care (May 2021)
- Palliative Care Australia
- World Health Organisation 2020 Palliative Care

Version and Approval History

Date	Version	Version and approval notes
August 2021	DRAFT	Draft version commenced.
September 2021	DRAFT	Draft for Comment period.
October 2021	DRAFT	Final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
December 2021	1	Approved at Clinical and Quality Council.
7 June 2024	1.1	Minor review by Palliative care working policy working party: updated electronic referral process, inclusion of Community Supportive care clinics, new referral forms. Approved by Executive Sponsor.
5 July 2024	1.2	Minor review: updated information and referral forms for POWH Community services. Approved by Executive Sponsor.

Appendices

Appendix 1: St George, Sutherland and Calvary Healthcare Referral for Specialist Palliative Care Medical Consultation Form

Referral for Specialist Palliative Care Medical Consultation	FAMILY NAME	
	GIVEN NAME	
	D.O.B. _____/_____/_____	☐ MALE ☐ FEMALE
	ADDRESS	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

TRIAGE PRIORITY

❒ **Urgent:** 1-2 weeks ❒ **Semi Urgent:** within 4 weeks

❒ **Routine:** 4-6 weeks ❒ **Non Urgent:** 6-8 weeks

Please include consultants in any ongoing correspondence

If **Urgent** (patient requires attendance at first available clinic) please call Consultant to discuss

If patient requires home based palliative care or is unable to attend clinic, please refer to CPCT : ph 9553-3444 or email SESLHD-Calvary-CPCT@health.nsw.gov.au

REFERRED BY

Name: ..... Designation: .....

Organisation: ..... Provider no: .....

Phone: ..... Fax: .....

Sign: ..... Date: ...../...../.....

PATIENT DETAILS

Title: ..... First Name: ..... Last Name: .....

Date of Birth: ...../...../..... Age: ..... Religion: .....

Address: .....

.....

Patient's Phone No's: H: ..... M: .....

Country of Birth: ..... Preferred Language: ..... Interpreter ❒ Yes ❒ No

Does the patient live alone? ❒ Yes ❒ No Is the patient or carer aware of the referral? ❒ Yes ❒ No

Other significant family/social: .....

.....

.....

ADVANCE CARE PLANNING

Is there an Advance Care Plan? ❒ Yes ❒ No ❒ Discussed ❒ Unknown *(❒ If yes, copy attached)*

Is there an Appointed Guardian? ❒ Yes ❒ No ❒ Discussed ❒ Unknown

Who is the person responsible if required? .....

Contact details: .....

Are the patient and family aiming for terminal care at home? ❒ Yes ❒ No ❒ Unsure

Please describe the patient's insight into their disease and prognosis: .....

.....

.....

STAFF SAFETY Are you aware of any potential risks to staff safety ❒ Yes ❒ No

Please describe: .....

.....

PSYCHOSOCIAL Does the patient or carer demonstrate emotional or spiritual distress? ❒ Yes ❒ No

Please describe: .....

.....

Are there any social workers/psychologists/counsellors involved in care? ❒ Yes ❒ No

If yes, please provide details: .....

.....

Are there any other Physical needs? ❒ Yes ❒ No

Please describe: : .....

.....

Referral for Specialist Palliative Care Medical Consultation	FAMILY NAME	
	GIVEN NAME	
	D.O.B. _____/_____/_____	☐ MALE ☐ FEMALE
	ADDRESS	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL INFORMATION ❒ *Or See Attached Document*

Palliative Diagnosis: .....

Allergies: .....

Other Significant Medical History: .....

.....

.....

.....

.....

REASON FOR THIS REFERRAL: *(select one or more)*

❒ **Complex Pain/Symptom Control** ❒ **End Of Life At Home** ❒ **Advance Care Planning** ❒ **Other**

.....

.....

.....

.....

.....

.....

SERVICE PROVIDERS

GP Name:	GP's Phone:
Specialist:	Location:
Specialist:	Location:
Community Nurses: ❒ Yes ❒ No	Other services involved:
Chemotherapy: ❒ Yes ❒ No	Radiotherapy: ❒ Yes ❒ No

.....

.....

.....

.....

.....

MEDICATION ❒ *Or See Attached*

MOBILITY STATUS

1. Independently Mobile	❒	4. Mobile with assistance of 1	❒
2. Mobile with walking aid	❒	5. Mobile with assistance of 2	❒
3. Mobile with Supervision	❒	6. In bed all of the time	❒

Appendix 2: Community Palliative Care Team (CPCT) referral form

COMMUNITY PALLIATIVE CARE TEAM REFERRAL FORM

Calvary Health Care Kogarah

Please return completed form to:
Fax: 02) 9553-3366
Email: SESLHD-Calvary-CPCT@health.nsw.gov.au

FAMILY NAME
GIVEN NAME
D.O.B. _____/_____/_____ ☐ MALE ☐ FEMALE
ADDRESS

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRED BY Name: ..... Designation: .....
Organisation: ..... Location: .....
Phone: ..... Fax: ..... Referring MO: .....
Sign: ..... Date: ..... / ..... / .....

PATIENT DETAILS ❒ Male ❒ Female ❒ Married/De-facto ❒ Widowed ❒ Divorced ❒ Never Married
Indigenous Status: ❒ Aboriginal ❒ Torres Strait Islander ❒ Aboriginal & TSI ❒ Neither
Title: ..... First Name: ..... Last Name: .....
Date of Birth: ..... / ..... / ..... Age: ..... Religion: .....
Address: .....
.....
Patient's Phone No's: H: ..... M: .....
Country of Birth: ..... Preferred Language: ..... Interpreter ❒ Yes ❒ No
DVA Number: ..... Gold Card ❒ Yes ❒ No
Health Fund Name: ..... Number: .....
Pension number: ..... Medicare No: .....

CARER DETAILS
Who should we contact regarding this referral: ❒ Patient ❒ 1st contact
Has the patient consented sharing medical information with the contact person: ❒ Yes ❒ No

1st Contact:	Relationship to patient:
Phone:	Lives with patient? ❒ Yes ❒ No
Carer:	Relationship to patient:
Phone:	Lives with patient? ❒ Yes ❒ No

Does the patient live alone? ❒ Yes ❒ No Is the patient or carer aware of the referral? ❒ Yes ❒ No
Other significant family / social summary: .....
.....
.....

SERVICE PROVIDERS

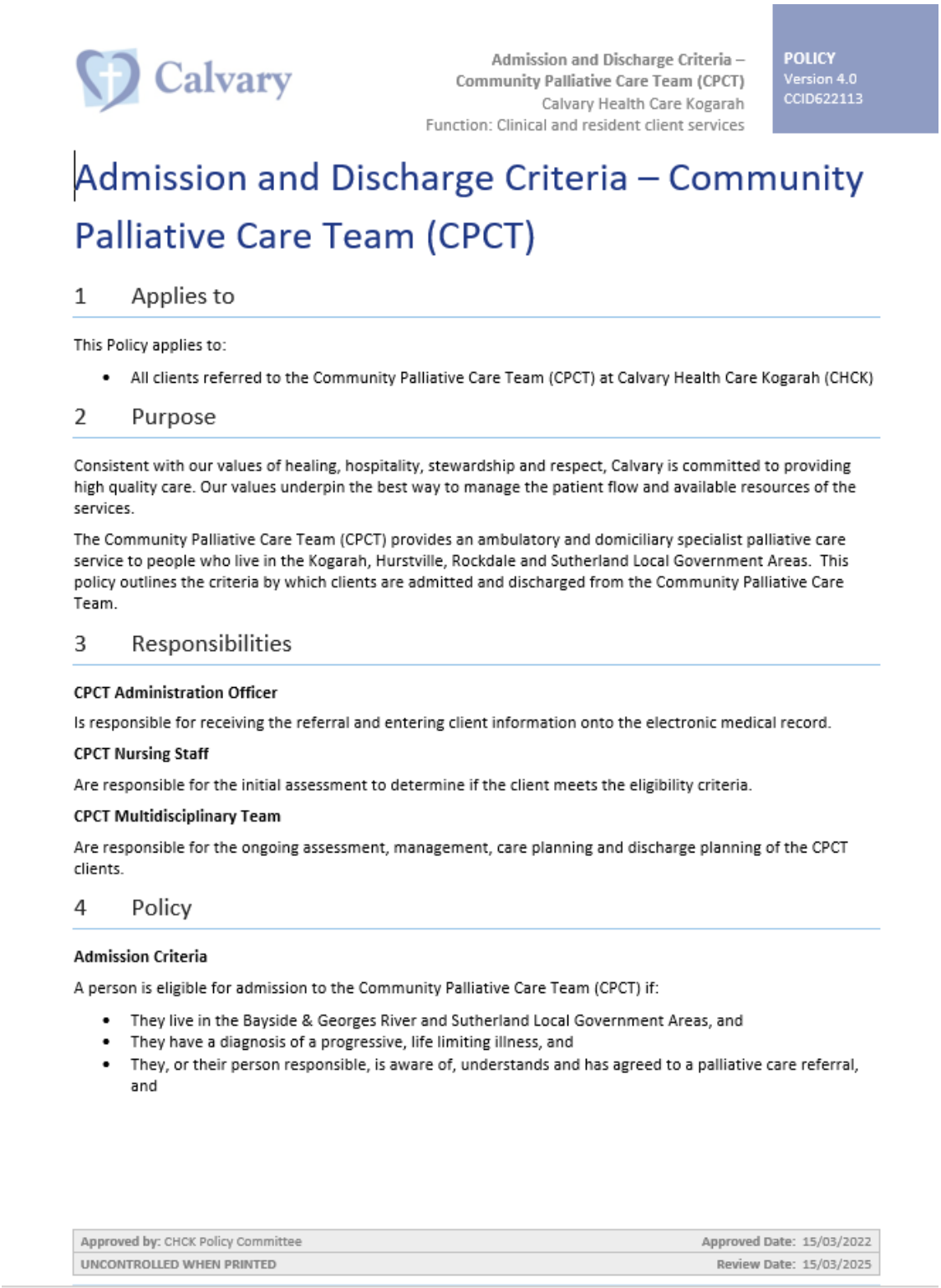
GP Name:	GP's Phone:
Specialist:	Location:
Specialist:	Location:
Community Nurses: ❒ Yes ❒ No	Other services involved:

Chemotherapy: ❒ Yes ❒ No Location: ..... Doctor: ..... Date: .....
Radiotherapy: ❒ Yes ❒ No Location: ..... Doctor: ..... Date: .....

ADVANCE CARE PLANNING
Has the patient's Resuscitation Status been discussed? ❒ Yes ❒ No
Is there an Advance Care Plan? ❒ Yes ❒ No ❒ Discussed ❒ Unknown *(❒If yes, copy attached)*
Is there an EPOA? ❒ Yes ❒ No ❒ Discussed ❒ Unknown
Please describe the patient's insight into their disease and prognosis: .....

COMMUNITY PALLIATIVE CARE REFERRAL FORM

Appendix 3: Admission and Discharge Criteria – Community Palliative Care Team (CPCT)



Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 4.0
CCID622113

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)

1 Applies to

This Policy applies to:

- All clients referred to the Community Palliative Care Team (CPCT) at Calvary Health Care Kogarah (CHCK)

2 Purpose

Consistent with our values of healing, hospitality, stewardship and respect, Calvary is committed to providing high quality care. Our values underpin the best way to manage the patient flow and available resources of the services.

The Community Palliative Care Team (CPCT) provides an ambulatory and domiciliary specialist palliative care service to people who live in the Kogarah, Hurstville, Rockdale and Sutherland Local Government Areas. This policy outlines the criteria by which clients are admitted and discharged from the Community Palliative Care Team.

3 Responsibilities

CPCT Administration Officer

Is responsible for receiving the referral and entering client information onto the electronic medical record.

CPCT Nursing Staff

Are responsible for the initial assessment to determine if the client meets the eligibility criteria.

CPCT Multidisciplinary Team

Are responsible for the ongoing assessment, management, care planning and discharge planning of the CPCT clients.

4 Policy

Admission Criteria

A person is eligible for admission to the Community Palliative Care Team (CPCT) if:

- They live in the Bayside & Georges River and Sutherland Local Government Areas, and
- They have a diagnosis of a progressive, life limiting illness, and
- They, or their person responsible, is aware of, understands and has agreed to a palliative care referral, and

Approved by: CHCK Policy Committee | Approved Date: 15/03/2022
UNCONTROLLED WHEN PRINTED | Review Date: 15/03/2025

- They and/or their family has at least one of the following:
  - Complex pain or symptoms, associated with the life limiting illness, requiring specialist multidisciplinary team management and/or after hours support,
  - A level of emotional, spiritual and/or psychosocial distress or social problems, associated with the disease or prognosis, that requires substantial multidisciplinary team support,
  - A poor prognosis, anticipated median survival less than 3 months, (time frame depends completely upon symptom burden & clinical need), requiring End of Life Care.

Referral

- Referrals are received from General Practitioners (GPs), Acute and Sub-Acute Care Hospital, Residential Aged Care Facilities (RACFs), Community Health Services - Fax: 02) 9553-3366
  Email: SESLHD-Calvary-CPCT@health.nsw.gov.au with other relevant information such as:
  - Hospital discharge summary as relevant
  - Pathology results,
  - Current medication list,
  - Radiology results, and
  - Medical correspondence
- The CPCT administration officer enters the patient's details into the electronic community health medical record.

Allocation

- All new referrals will be allocated to a CPCT Clinical Nurse Specialist (CNS) / Registered Nurse (RN) / Nurse Practitioner (NP) according to residential address.
- Clients will be triaged by the CNS / RN into either the Palliative Ambulatory Care Clinic or home visit including Residential Aged Care Facility (RACF) dependent on triage criteria after a telephone consultation with the allocated CPCT CNS / RN /NP
- Clients are contacted within 48 hours of referral and triaged for service type and timeframe for initial assessment according to their specific needs.

Assessment, Admission and Planning

- The CPCT CNS / RN /NP conducts the initial assessment. If the client meets the admission criteria the CPCT nurse admits the client to the CPCT; completes the client consent form and refers the client to other CPCT multidisciplinary team members as appropriate.
- The client and/or family are given an information pack that includes information on privacy and rights and responsibilities.
- The clients will be reviewed by the appropriate multidisciplinary team members as per the patient's care plan until they are stable.
- If the client remains stable, they will be reviewed in regards to discharge from CPCT and any other appropriate referrals for ongoing support.
- The client's day to day needs, i.e. personal care, transport, meals, medications, are supported by local community services and GP's.
- After hours phone numbers are given to the client and carers.
- The CPCT nurse sends a letter to the GP.

Shared Care Models

- Shared patient care models can exist with, but is not limited to, the following teams
  - Sydney Children's Hospital
  - Generalist nursing teams in the relevant LGAs
  - Specialist Chronic Disease teams (Heart Failure, RCCP, Haemodialysis service)

- The goal of shared care partnerships between the above teams and the CPCT is to provide a seamless service for clients with a life limiting illness.
- Shared care will be dependent on the client / carers' needs at any given time within the disease trajectory. This seamless service is achieved by effective handovers to primary carers' and transfers between services with the client receiving the appropriate care at the appropriate time without duplicating services.
- The option for after-hours emergency consultative phone service by the client will be available from Calvary Health Care Kogarah and active consultation and input from the CPCT nurses remains available to the client when deemed necessary by the shared care partners.

Paediatrics

- The CPCT may provide shared care in the care of children under the age of 16 years with the specialist palliative care paediatric team at Sydney Children's Hospital (SCH).
- The paediatric team is the primary provider of care and the palliative care community team provides support to paediatric clients as negotiated. Care is provided to paediatric clients by the medical and nursing staff Monday – Friday 0800 – 1630 hours.
- Discussion regarding client care planning occurs between the CPCT and the specialist paediatric palliative care team at SCH. All clients have a medical review by a Calvary palliative care medical consultant on admission to the service and the shared care relationship is established.
- The after-hours service is available for paediatric clients.
- Allied health services do not provide services to paediatric clients.

Criteria for Discharge from the CPCT

- Clients will be discharged from the Community Palliative Care Team for the following reasons:
  - If they do not require specialist palliative care support for greater than 4 weeks.
  - If the client moves out of the geographical area covered by CPCT.
  - Following the client's death.
- Clients discharged for the reason of not requiring specialist palliative care support will be discharged back into the care of the GP or other Primary Health teams and may be re-referred as their condition requires.
- Discharging of clients is done in consultation with CPCT Medical Consultant or Nurse Practitioner. The client's GP is notified by letter.

Admission to the Inpatient Palliative Care Unit (PCU)

- CPCT clients may be admitted to the PCU if required and if they meet the admission criteria. Please refer to the CHCK Policy: Policy 13: Admission Criteria and Process – Inpatient Palliative Care Unit.

5 Related Calvary Documents

- Admission Criteria and Processes – Palliative Care

6 Definitions

- **Terminal Care** death is likely; the aim is to focus on the physical, emotional and spiritual needs. Discharge is not expected.
- **Pain and Symptom Management** the client is experiencing distress from pain or a symptom related to their illness. The aim of the admission is to minimise or alleviate the distress and discharge is expected.

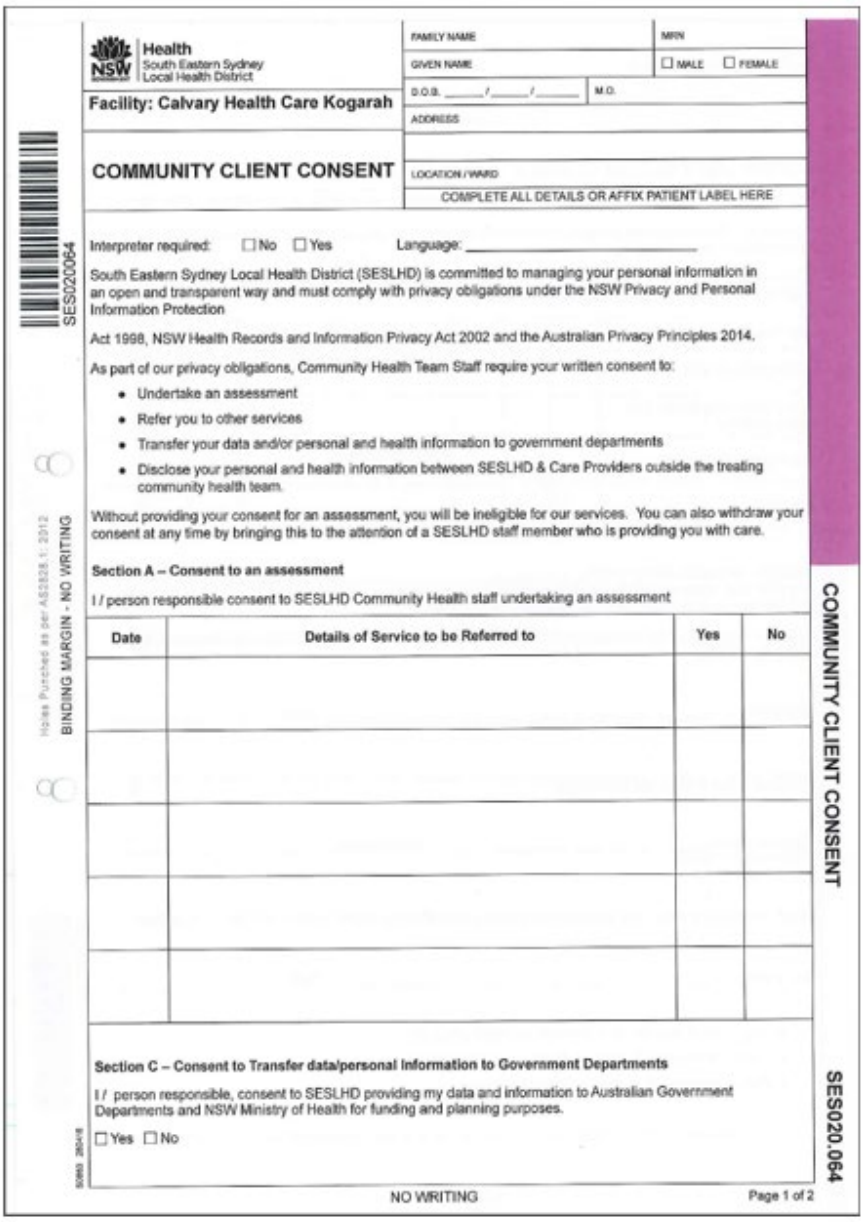
- **Specialist Paediatric Palliative Care Team** based at the Sydney Children's Hospital in Randwick and the Paediatric palliative care service from the Children's Hospital at Westmead and Bear Cottage, Manly.

7 References

- ACHS EQuIP National Standards – 2nd Edition:
  - Standard 5 Comprehensive Care

8 Appendix

Appendix 1



Health
South Eastern Sydney
Local Health District

Facility: Calvary Health Care Kogarah

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES020064

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

COMMUNITY CLIENT CONSENT

Interpreter required: ☐ No ☐ Yes Language: _____

South Eastern Sydney Local Health District (SESLHD) is committed to managing your personal information in an open and transparent way and must comply with privacy obligations under the NSW Privacy and Personal Information Protection

Act 1998, NSW Health Records and Information Privacy Act 2002 and the Australian Privacy Principles 2014.

As part of our privacy obligations, Community Health Team Staff require your written consent to:

- Undertake an assessment
- Refer you to other services
- Transfer your data and/or personal and health information to government departments
- Disclose your personal and health information between SESLHD & Care Providers outside the treating community health team.

Without providing your consent for an assessment, you will be ineligible for our services. You can also withdraw your consent at any time by bringing this to the attention of a SESLHD staff member who is providing you with care.

Section A – Consent to an assessment

I / person responsible consent to SESLHD Community Health staff undertaking an assessment

Date	Details of Service to be Referred to	Yes	No

Section C – Consent to Transfer data/personal Information to Government Departments

I / person responsible, consent to SESLHD providing my data and information to Australian Government Departments and NSW Ministry of Health for funding and planning purposes.

☐ Yes ☐ No

SES020.064

NO WRITING

Page 1 of 2

Calvary

Admission and Discharge Criteria – Community Palliative Care Team (CPCT)
Calvary Health Care Kogarah
Function: Clinical and resident client services

POLICY
Version 4.0
CCID622113

Health
South Eastern Sydney
Local Health District

Facility: Calvary Health Care Kogarah

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

COMMUNITY CLIENT CONSENT

Section D – Consent for my personal & health information to be shared between Community Health staff and other relevant care providers.

I / person responsible give consent for my personal & health information to be shared between community health staff and other relevant care providers/organisations ticked below:

Service Provider/Organisation	Yes	No	N/A	Service Provider/Organisation	Yes	No	N/A
Other SESLHD staff				Family Members (specify)			
Other Community Health Staff within SESLHD							
My General Practitioner				Others (specify):			
Medicare							

I / person responsible, (insert name) _____ confirm that the information which I have provided in sections A, B, C, & D is correct, and that SESLHD is able to access and disclose my personal, health and data information as indicated.

I / person responsible have been provided with information on brochures on Patient's Rights and Responsibilities and Patient Privacy.

Signature: _____ **Date:** _____

_____
Relationship to client (if client unable to give consent)

Clinician Name: _____ **Designation:** _____
(Person obtaining consent)

I have explained the above and completed the patient 3 Point ID check (Name, Date of Birth, Medicare Number)

Signature: _____ **Date:** _____

- 'Rights and Responsibilities' Brochure explained and given ☐
- 'Privacy Information for Patients' Brochure explained and given ☐
- Service Brochure (if available) explained and given ☐

Please Note: Health Department client records are kept both electronically and in paper form

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SES020064

Page 2 of 2 NO WRITING

Approved by: CHCK Policy Committee | Approved Date: 15/03/2022
UNCONTROLLED WHEN PRINTED | Review Date: 15/03/2025

Page 6 of 8

Continuing the Mission of the Sisters of the Little Company of Mary

Appendix 4: Residential Aged Care: Palliative Care Referral

Health South Eastern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Calvary Health Care Kogarah	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

All sections must be completed and returned to the CPCT admin officer via:
Email: SESLHD-calvary-kogarahPCNR@health.nsw.gov.au
Or Fax: 02 9553 3366

REFERRED BY (To be completed by RACF)

Name: _____ Designation: _____

Organisation: _____

Phone: _____ Fax: _____

Sign: _____ Date: _____ / _____ / _____

ALL CRITERIA MUST BE CONSIDERED BEFORE SENDING THE REFERRAL

Referral Criteria (All efforts should be made to ensure criteria 1 & 2 have been met before sending the referral)

1. **The General Practitioner has agreed to a palliative care review** ☐
2. **The resident and or family have agreed to a palliative care review** ☐

TRIAGE PRIORITY

WILL BE BASED ON THE LEVEL OF CLINICAL DISTRESS AND SEVERITY OF SYMPTOMS.

If urgent or unsure, please phone 9553-3444 to discuss.

PACOP - Phase:_____ RUG:_____ AKPS:_____

☐ Deteriorating ☐ Terminal

3. **POORLY CONTROLLED SYMPTOMS & CLINICAL CONCERNS (Please tick):**

☐ Pain	☐ Nausea	☐ Shortness of breath	☐ Delirium
☐ Significant weight loss		☐ Worsening swallow	☐ Increase in hospital admissions
☐ Existential distress		☐ End of life with no plan in place	☐ Recent/recurrent infections
☐ Requires case conference/family meeting where there is conflict about goals of care			
☐ Other: _____			

General Practitioner name	
Phone	
Fax	

Please attach copies of (if available):

1. Goals of care discussion — Yes ☐ Date:_____
2. Advance care plan — Yes ☐ Date:_____
3. Medication chart including PRN medications — Yes ☐
4. Latest hospital discharge summary — Yes ☐

NO WRITING

Page 1 of 2

Health South Eastern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Calvary Health Care Kogarah	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Patient Details:

Title:	**First Name:**	**Last Name:**

Facility name and address:

Facility phone number:

M ☐ F ☐	Date of Birth:	Age:	Religion:

Country of Birth?	Language Spoken?	Interpreter needed? ☐ Yes ☐ No

Carer Details

1st Contact:	Relationship to patient:

Phone: Home: Work: Mobile:

2nd Contact:	Relationship to patient:

Phone: Home: Work: Mobile:

Medical Diagnosis (DO NOT leave blank):

Reason for referral (What's changed? What is causing distress?):

What actions have been taken?

Office use only:

☐ Urgent
☐ Semi Urgent
☐ Non-Urgent

Note:

Version Aug 23

NO WRITING

Page 2 of 2

Appendix 5: Prince of Wales Hospital Internal Palliative Care Referral Form

Nelune Comprehensive Cancer Centre

Research led excellence in cancer care

THE BRIGHT ALLIANCE | UNSW

Staff Specialists:

Dr Rebecca Strutt (Head of Department)
Dr Helen Herz
Dr Daniel Chim
Dr Gemma Ingham
Dr Shawna Koh
Dr Isuru Ratnayake

Email: SESLHD-POWH-PalliativeCare@health.nsw.gov.au

Palliative Care
Prince of Wales Hospital
Bright Building, Level 1
Randwick NSW 2031

Phone: (02) 9382 5108
Fax: (02) 9382 0422

Internal Palliative Care Referral Form

Date of Referral: 06/...../20.....

Dear Dr .....
Department of Palliative Care
Prince of Wales Hospital

Thank you reviewing my patient ..... MRN .....

The diagnosis is .....

.....

.....

The specialist palliative care needs are.....

.....

.....

.....

.....

This patient: ☐ has consented to referral to palliative care and is agreeable to the service (required).

This patient: ☐ is well enough to come to a palliative care clinic
OR
☐ is not as well, and review at their home is preferred

This referral will be valid for a period of 90 days.

Signature .....

Name ..... Provider No. .....

Health
South Eastern Sydney
Local Health District

A Centre for Multidisciplinary Cancer Treatment and Research
A Facility of the South Eastern Sydney Local Health District

Nelune Comprehensive Cancer Centre

Research led excellence in cancer care

THE BRIGHT ALLIANCE | UNSW AUSTRALIA

Staff Specialists:

Dr Rebecca Strutt (Head of Department)
Dr Helen Herz
Dr Daniel Chim
Dr Gemma Ingham
Dr Shawna Koh
Dr Isuru Ratnayake

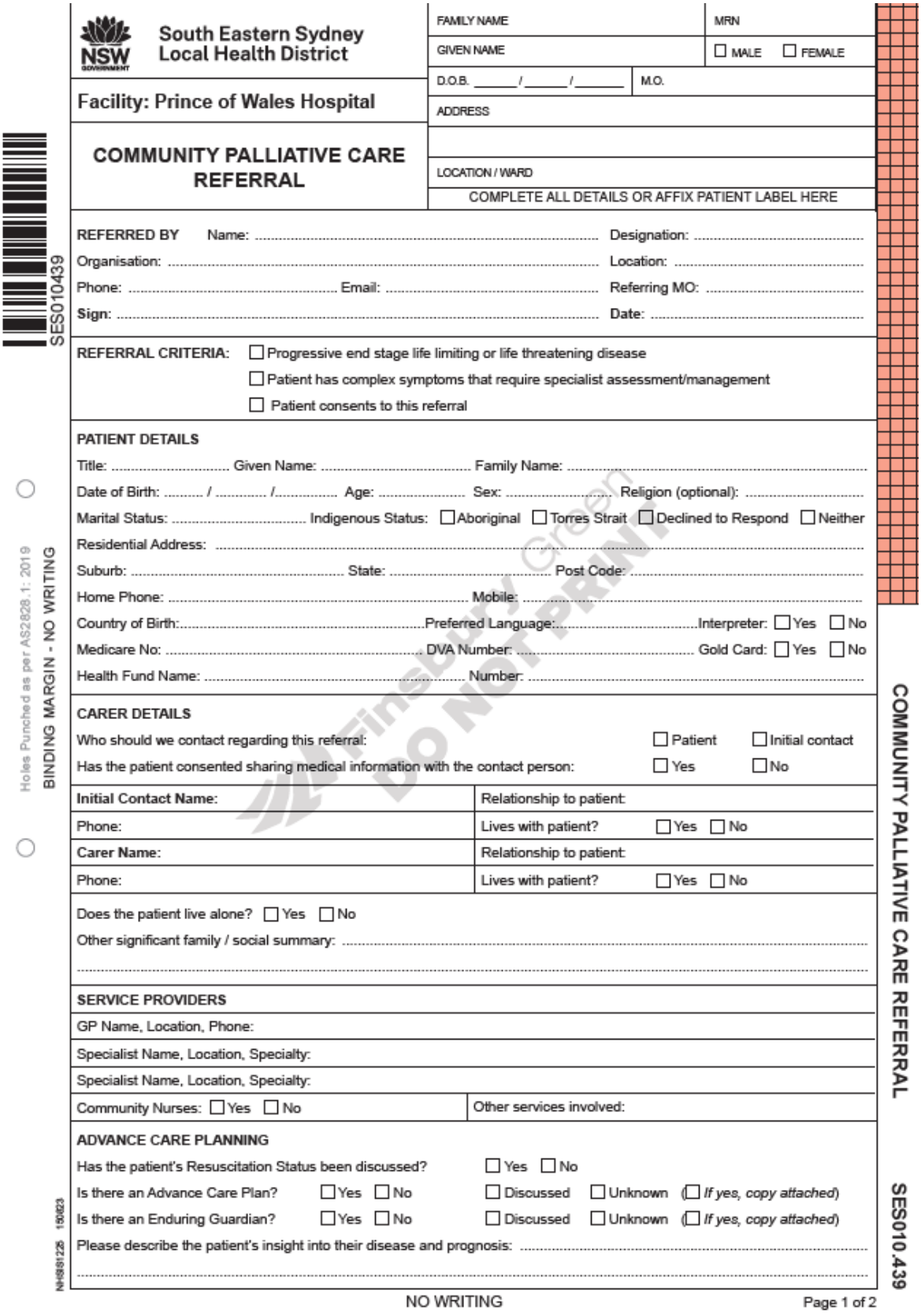
Email: SESLHD-POWH-PalliativeCare@health.nsw.gov.au

Palliative Care
Prince of Wales Hospital
Bright Building, Level 1
Randwick NSW 2031

Phone: (02) 9382 5108
Fax: (02) 9382 0422

***return** form to email address or fax listed above**

Appendix 6: Prince of Wales Community Palliative Care Referral Form



South Eastern Sydney Local Health District

Facility: Prince of Wales Hospital

COMMUNITY PALLIATIVE CARE REFERRAL

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010439

REFERRED BY Name: ..... Designation: .....
Organisation: ..... Location: .....
Phone: ..... Email: ..... Referring MO: .....
Sign: ..... **Date:** .....

REFERRAL CRITERIA:
☐ Progressive end stage life limiting or life threatening disease
☐ Patient has complex symptoms that require specialist assessment/management
☐ Patient consents to this referral

PATIENT DETAILS
Title: ..... Given Name: ..... Family Name: .....
Date of Birth: ..... / ..... / ..... Age: ..... Sex: ..... Religion (optional): .....
Marital Status: ..... Indigenous Status: ☐ Aboriginal ☐ Torres Strait ☐ Declined to Respond ☐ Neither
Residential Address: .....
Suburb: ..... State: ..... Post Code: .....
Home Phone: ..... Mobile: .....
Country of Birth: ..... Preferred Language: ..... Interpreter: ☐ Yes ☐ No
Medicare No: ..... DVA Number: ..... Gold Card: ☐ Yes ☐ No
Health Fund Name: ..... Number: .....

CARER DETAILS
Who should we contact regarding this referral: ☐ Patient ☐ Initial contact
Has the patient consented sharing medical information with the contact person: ☐ Yes ☐ No

Initial Contact Name:	Relationship to patient:
Phone:	Lives with patient? ☐ Yes ☐ No
Carer Name:	Relationship to patient:
Phone:	Lives with patient? ☐ Yes ☐ No

Does the patient live alone? ☐ Yes ☐ No
Other significant family / social summary: .....
.....

SERVICE PROVIDERS
GP Name, Location, Phone:
Specialist Name, Location, Specialty:
Specialist Name, Location, Specialty:
Community Nurses: ☐ Yes ☐ No | Other services involved:

ADVANCE CARE PLANNING
Has the patient's Resuscitation Status been discussed? ☐ Yes ☐ No
Is there an Advance Care Plan? ☐ Yes ☐ No ☐ Discussed ☐ Unknown (☐ *If yes, copy attached*)
Is there an Enduring Guardian? ☐ Yes ☐ No ☐ Discussed ☐ Unknown (☐ *If yes, copy attached*)
Please describe the patient's insight into their disease and prognosis: .....
.....

BINDING MARGIN - NO WRITING
Holes Punched as per AS2828.1: 2019
NHS91126 150623
COMMUNITY PALLIATIVE CARE REFERRAL
SES010.439
NO WRITING
Page 1 of 2

South Eastern Sydney
Local Health District

Facility: Prince of Wales Hospital

COMMUNITY PALLIATIVE CARE REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL INFORMATION ☐ *Or See Attached Document*

Main Diagnosis: .....

Secondary Diagnosis:

Allergies: .....

Other Significant Medical History: .....

.....

.....

Reason for Referral:

☐ Pain management	☐ Psychosocial
☐ Other symptom management	☐ Allied Health Support
☐ End of Life Care at Home	☐ Admission to Palliative Care Unit

Functional status: ☐ independent ☐ partial assist ☐ full assist Aids: .....

Are there any other Physical needs? ☐ Yes ☐ No

Please describe: .....

.....

STAFF SAFETY

Are you aware of any potential risks to **Staff Safety** when visiting at home? ☐ Yes ☐ No

Please describe: .....

.....

PSYCHOSOCIAL

Does the patient or carer demonstrate **emotional or spiritual distress?** ☐ Yes ☐ No

Please describe: .....

.....

.....

Are there any social workers/psychologists/counsellors involved in care? ☐ Yes ☐ No

If yes, please provide details: .....

.....

Please attach any of the following:

☐ Medical history record	☐ Discharge Summaries
☐ Current medication list	☐ Specialist correspondence
☐ Advance Care Plan/Directive	☐ Recent investigations

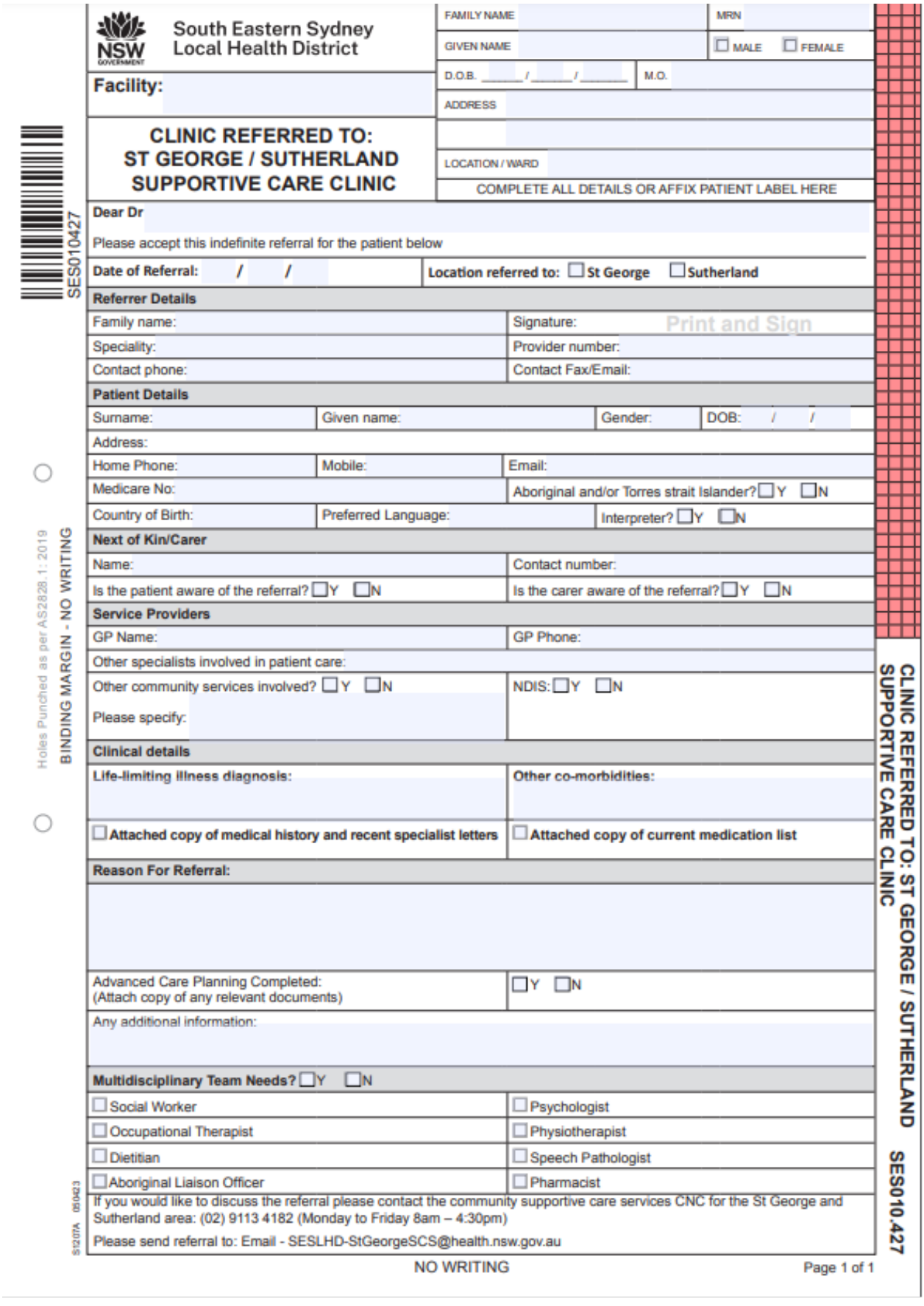
Completed forms can be launched directly through the Healthlink portal or faxed to 9382 0422

Prince of Wales Hospital Community Palliative Care Team	Phone: 9382 5111 Fax: 9382 0422 Email: SESLHD-POWH-PalliativeCare@health.nsw.gov.au Hospital Switchboard number: 9382 2222

Page 2 of 2

NO WRITING

Appendix 7: St George Supportive Care Service



South Eastern Sydney Local Health District

Facility:

CLINIC REFERRED TO: ST GEORGE / SUTHERLAND SUPPORTIVE CARE CLINIC

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010427

Dear Dr

Please accept this indefinite referral for the patient below

Date of Referral: / / | **Location referred to:** ☐ St George ☐ Sutherland

Referrer Details

Family name:	Signature: Print and Sign
Speciality:	Provider number:
Contact phone:	Contact Fax/Email:

Patient Details

Surname:	Given name:	Gender:	DOB: / /
Address:			
Home Phone:	Mobile:	Email:	
Medicare No:		Aboriginal and/or Torres strait Islander? ☐Y ☐N	
Country of Birth:	Preferred Language:	Interpreter? ☐Y ☐N	

Next of Kin/Carer

Name:	Contact number:
Is the patient aware of the referral? ☐Y ☐N	Is the carer aware of the referral? ☐Y ☐N

Service Providers

GP Name:	GP Phone:
Other specialists involved in patient care:	
Other community services involved? ☐Y ☐N Please specify:	NDIS: ☐Y ☐N

Clinical details

Life-limiting illness diagnosis:	**Other co-morbidities:**
☐ **Attached copy of medical history and recent specialist letters**	☐ **Attached copy of current medication list**

Reason For Referral:

Advanced Care Planning Completed: (Attach copy of any relevant documents)	☐Y ☐N
Any additional information:	

Multidisciplinary Team Needs? ☐Y ☐N

☐ Social Worker	☐ Psychologist
☐ Occupational Therapist	☐ Physiotherapist
☐ Dietitian	☐ Speech Pathologist
☐ Aboriginal Liaison Officer	☐ Pharmacist

If you would like to discuss the referral please contact the community supportive care services CNC for the St George and Sutherland area: (02) 9113 4182 (Monday to Friday 8am – 4:30pm)

Please send referral to: Email - SESLHD-StGeorgeSCS@health.nsw.gov.au

NO WRITING

Page 1 of 1

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

CLINIC REFERRED TO: ST GEORGE / SUTHERLAND SUPPORTIVE CARE CLINIC
SES010.427

S1207A 050423

Appendix 8: The Sutherland Hospital Outpatient Department Referral form

The Sutherland Hospital Outpatient Department

Patient Referral Form

The Sutherland Hospital Outpatient Department
Cnr of Kingsway and Kareena Rd,
Caringbah NSW 2229

Phone: 9540 7067
Fax: 9540 8067
Email: SESLHD-TSH-Outpatients@health.nsw.gov.au

Referral to Dr *(one named clinician)*

Outpatient Clinic use only

Referral received:

Referrer notified of receipt:

Clinic/Doctors

Respiratory and Sleep
Dr Clarissa Susanto
Dr Adelle Jee
Dr Chin Goh
Dr Vicki Chang
Dr Con Archis
Dr Johnathan Man

Neurology
Dr Ik Lin Tan
Dr Manisha Narasimhan
Dr Benjamin Nham
Dr Rajiv Wijesinghe
Dr Sully Fuentes-Patarroyo
Dr Derrick Soh

Paediatrics
PH- 9540 7384
Dr Alys Swindlehurst
Dr Henry Gilbert
Dr James Tong
Dr Elizabeth Berger

Gynaecology
PH-9540 7240
Dr Amani Harris
Dr Dean Conrad
Dr John Breen
Dr Chandra Krishnan

Palliative Care
PH 9540 8453
Dr Camilla Chan – Palliative and Supportive Care MDT
Dr Jessica Jones – Palliative Care
Dr Johnathon Man- Respiratory Supportive Care
Dr Taching Tan- Cardiac Supportive care

Infectious Diseases:
Dr Ben Kippenberg
Dr Roselle Robosa

Rehabilitation
Dr Lucy Ramon
Dr Eunice Lin

Endocrinology
Dr Malgorzata Brzozowska
Dr Michael Bennett
Dr Ganesh Chockalingam
Dr Matthew Luttrell

Dermatology
PH-9540 8321
Dr John Sullivan

Patient Details

Patient Name:	
Title	
DOB	
Address	
Sex/Gender	☐ Male ☐ Female ☐ X (indeterminate/intersex/unspecified)
Phone	
Email	
Compensable Status	☐ DVA ☐ WorkCover ☐ Motor Vehicle Third Party Insurance ☐ Other
Identifies as Aboriginal or Torres Strait Islander origin	☐ YES ☐ NO
Interpreter required Language	☐ YES ☐ NO .....
Medicare Number	

Clinical Details

Reason for Referral *(including presenting symptoms – onset, duration and severity, if appropriate – and physical findings)*	
Any previous treatment or investigations for referral condition	
Any previous surgery	
Any other co-existing conditions	
Any current medication (including any allergies)	

Referrer Details

Name	☐ GP ☐ Other
Provider Number	
Phone	
Email	
Fax	
Signature	
Date	

Other details if required

Appendix 9: POWH Residential Aged Care Service Referral Form

Health
South Eastern Sydney
Local Health District

	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Prince of Wales Hospital	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please return completed form to:
Email: SESLHD-POWH-PalliativeCare@health.nsw.gov.au
F: 02 9382 5170 P: 02 9382 5108

REFERRED BY

Name: _____ Designation: _____

Organisation: _____

Phone: _____ Fax: _____

Sign: _____ Date: _____ / _____ / _____

Please COMPLETE triage priority

Priority:

☐ **Urgent:** assess within 48 hours. Please phone on 02 9382 5108

☐ **Semi Urgent:** assess within 2 to 5 days.

☐ Non Urgent: assess within 6 to 13 days.

ALL CRITERIA MUST BE CONSIDERED PRIOR TO SENDING THE REFERRAL

Referral Criteria

1. **The resident and or family have agreed to a palliative care review** ☐
2. **The resident has specialist palliative care needs not managed within current plan:**
   a. **Poorly controlled symptoms including (but not limited to) pain, nausea, shortness of breath possibly related to an exacerbation of an existing condition** ☐
   b. **Changes in resident function including increasing falls/reduced mobility, significant weight loss/worsening swallow, increasingly bed bound or an increase in hospital presentations** ☐
   c. **Support and advice needed at a palliative care case conference/family meeting where the resident and/or family are experiencing complex physical/psychological issues OR where there is conflict about goals of care at end of life** ☐
3. **The General Practitioner has agreed to palliative care involvement** ☐

General Practitioner name

GP Phone | GP Fax/Email

Specialist's patient known to (*include specialty*):

Please attach copies:

1. Goals of care discussion Yes ☐
2. Advance care plan Yes ☐
3. Medication chart (*with PRN medications and allergies*) Yes ☐
4. Latest hospital discharge summary/eMR notes Yes ☐

BINDING MARGIN – NO WRITING

RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL

NO WRITING

Page 1 of 2

Health South Eastern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. _____/_____/_____	M.O.
Facility: Prince of Wales Hospital	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PATIENT DETAILS

Title:	**First Name:**	**Last Name:**
Facility name and address:		
Facility phone number:		Medicare number:

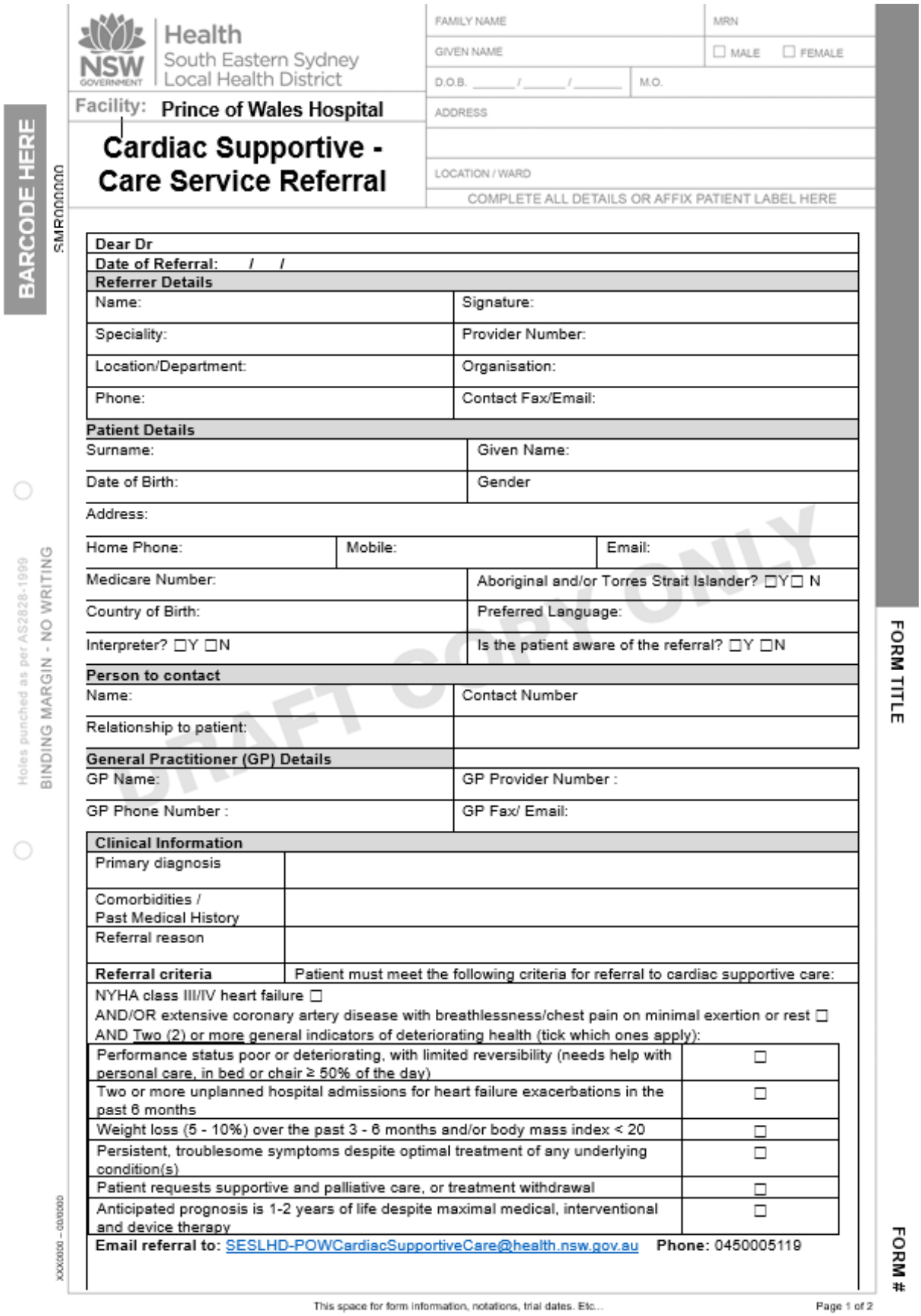
M ☐ F ☐	Date of Birth:	Age:	Religion:
Country of Birth:	Language Spoken:	Interpreter needed? ☐ Yes ☐ No	

Carer/NOK Details **Main Contact:**	Relationship to patient:
Phone Home: Work: Mobile:	
Additional Contact Name and Number:	
Main Diagnosis:	**Other medical history:**
Reason for referral:	
What actions have been taken to manage any distress for the resident?	
Is Patient Known to GFS? Yes ☐ No ☐	**Is Patient known to GOS?** Yes ☐ No ☐

NO WRITING

Page 2 of 2

Appendix 10: POWH Cardiac Supportive Care Service Referral Form



Health
South Eastern Sydney
Local Health District

Facility: Prince of Wales Hospital

Cardiac Supportive - Care Service Referral

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE

SMR000000

FORM TITLE

FORM #

Holes punched as per AS2828-1999 BINDING MARGIN - NO WRITING

DRAFT COPY ONLY

Dear Dr		
Date of Referral: / /		
Referrer Details		
Name:	Signature:	
Speciality:	Provider Number:	
Location/Department:	Organisation:	
Phone:	Contact Fax/Email:	
Patient Details		
Surname:	Given Name:	
Date of Birth:	Gender	
Address:		
Home Phone:	Mobile:	Email:
Medicare Number:	Aboriginal and/or Torres Strait Islander? ☐Y☐ N	
Country of Birth:	Preferred Language:	
Interpreter? ☐Y ☐N	Is the patient aware of the referral? ☐Y ☐N	
Person to contact		
Name:	Contact Number	
Relationship to patient:		
General Practitioner (GP) Details		
GP Name:	GP Provider Number :	
GP Phone Number :	GP Fax/ Email:	

Clinical Information	
Primary diagnosis	
Comorbidities / Past Medical History	
Referral reason	
Referral criteria	Patient must meet the following criteria for referral to cardiac supportive care:

NYHA class III/IV heart failure ☐
AND/OR extensive coronary artery disease with breathlessness/chest pain on minimal exertion or rest ☐
AND Two (2) or more general indicators of deteriorating health (tick which ones apply):

Performance status poor or deteriorating, with limited reversibility (needs help with personal care, in bed or chair ≥ 50% of the day)	☐
Two or more unplanned hospital admissions for heart failure exacerbations in the past 6 months	☐
Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20	☐
Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s)	☐
Patient requests supportive and palliative care, or treatment withdrawal	☐
Anticipated prognosis is 1-2 years of life despite maximal medical, interventional and device therapy	☐

Email referral to: SESLHD-POWCardiacSupportiveCare@health.nsw.gov.au **Phone:** 0450005119

xxxxxxx - 000000

This space for form information, notations, trial dates, Etc...

Page 1 of 2

Appendix 11: POWH Supportive Care MDT Clinic Referral Form

Palliative Community Supportive Care Services Referral Form

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

PCSS Referral Form 1