**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