Specialist Palliative Care Referral

For patients under 16 years, please refer to Children's Health Queensland (see 'Refer to section' for contact details)

An assessment and triage process by the palliative care team will aim to develop a management plan involving services that are appropriate to the patient's circumstance. ***Incomplete forms or absence of additional information will delay the process** *

If the matter is URGENT or OUTSIDE BUSINESS HOURS, please telephone switchboard and ask to be put through to the Palliative Care Doctor on call.*

Pages: _____of _____

Referral for: ☐ **MNHHS Pall Care Specialist Service Assessment** ☐ **NGO Domiciliary Palliative Care Service** ☐ **Both**	
Patient information	
Family Name: Given Name:	DOB
Address Perm/Temp	Sex☐ Female ☐ Male ☐ Indeterminate
Suburb Postcode	Medicare no.
Phone Mobile	Hospital /UR number
Support Organisation	Private Health Insurance
Preferred mail address	DVA no.

☐ End of Life Care Plan ☐ Advanced Health Directive ☐Lives alone

Indigenous status ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Unknown ☐ Neither

Country of birth_____ ☐ Interpreter required /Language _____

Alternative contact: ☐ **NOK** ☐ **EPOA** ☐ **Carer**	
Family Name: Given Name:	Phone Mobile:
Address	Relationship
Suburb Postcode	☐ To be present at assessment

Referring Consultant and/or GP details/discharge facilitator		**Ideal response time**
Date of referral	☐ GP same as referrer	☐ 24hrs (please call Consultant to discu
Referrer name	GP name	☐ 1 week
Referrer phone	GP phone	☐ Next available appointment
Referrer address	GP address	☐ Already Discussed with: Dr ……..(Registrar/Consulta Date: / /20
Specialty	Provider no.	***Phone calls must be followed up b written referral.***

Refer to: ☐ **Dr Bruce Stafford Red/Cab** ☐ **Dr James Stevenson TPCH** ☐ **Dr Carol Douglas RBWH**

Metro North Services

- ☐ **Redcliffe / Caboolture / Kilcoy Palliative Care Service**
  Phone: 07 3883 7777(Urgent medical referrals – ask for PCU Dr on call)
  Fax: 1300 364 952 SaAS-Palliative-Care@health.qld.gov.au
- ☐ **The Prince Charles Hospital**
  Phone: 07 3139 4000(Urgent medical referrals – ask for PCU Dr on call)
  Fax: 1300 364 952
- ☐ **Royal Brisbane and Women's Hospital**
  Inpatient referrals only(Urgent medical referrals – ask for PCU Dr on call)
  Phone: 07 3646 8111
- ☐ **Domiciliary Palliative Care**
  Phone: 1300 658 252 (CRU enquiries)
  SaAS-Palliative-Care@health.qld.gov.au
  Fax: 1300 364 952 (CPI Fax) or Fax: 3049 1260 (weekend domiciliary referrals only)

For Services outside of Metro North

Palliative Care Helpline
Phone: 1800 772 273

Paediatric Palliative Care Service (under 16)
Phone: 1800 249 648
Switch: 07 3068 1111
Email: ppcs@health.qld.gov.au

Life limiting illness

Primary diagnosis	Significant Co morbidities
Date of diagnosis	

Location of patient: Inpatient ☐ **Outpatient** ☐ **Expected Discharge Date:**_____

☐ Home ☐ RACF ☐ RBWH ☐ TPCH ☐ Redcliffe ☐ Caboolture ☐ Kilcoy Hospital

☐ If Private, please name_____ ☐ Other i.e. Interstate or Regional transfer of care_____

Supporting Documentation Required (must be attached)

Please ensure relevant detailed clinical correspondence and results accompany this form.

Indicate attachments accompanying referral: ☐ Clinical correspondence (Medical / Nursing /Allied Health) please circle

☐ Pathology results ☐ Current medication list ☐ Radiology results ☐ Advance Health Directive ☐ Other ……

Alerts/Comments: _____

Criteria for eligibility and a guide for referral to a palliative care service

If patient does not meet the three criteria below, please discuss your case with your local palliative care service

☐Patient has an advanced progressive, life limiting illness

☐ Patient or their decision maker is aware of, understands and has agreed to a palliative care referral

☐ Primary goals of patient care are to control symptoms, maximise function, maintain quality of life & provide comfort

Reason for Referral (Tick as many boxes as apply)

☐ Introduction to service for ongoing follow up care

☐ Assistance with specific problems

☐Nausea ☐Gastrointestinal ☐Psychosocial ☐Counselling ☐Spiritual ☐Functional

☐Pain ☐Neurological ☐Dyspnoea ☐Services/support ☐Other _____

☐ Difficulty maintaining care at place of residence

☐ Inpatient Consultation at MNHSS Facility/HSNS ☐ Outpatient Appointment ☐ Home Visit (criteria applies)

☐ Terminal Care

☐ Review with potential transfer of care/admission

☐ Other _____

Does the patient currently utilise mobile oxygen? ☐ Yes ☐ No

Is the patient capable of attending OPD clinic in a private vehicle/public transport? ☐ Yes ☐ No

Is the patient already known to domiciliary providers? ☐ Yes ☐ No Please state service_____

PCOC Data/Parameters: (complete if familiar with scoring)

PHASE: 1 2 3 4	KARNOFSKY SCORE: (0-100)
RUG SCORE: Bed Mob _____ Transfers_____ Toileting_____ Eating:_____	
Problem Severity Scores: (0-3) Pain: _____ Psych/Soc & Spirit: _____ Other Symptoms: _____ Family/Carer: _____	

MNHHS Palliative Specialist Service Use only

Plan: Accepted To Service☐ Yes☐ No (Referrer Notified Y/N)☐ Refer to NGO Domiciliary Agency

☐ Inpatient Consult RBWH/TPCH/HSNS/RED/CAB ☐ Admit to Designated PCU: TPCH/RED

☐OPD-Clinic RWBH/TPCH/PINE RIVERS/NTHWEST/RED/CAB/NTHLAKES ☐Nurse Practitioner: HOME / RACF

Triaged by: Signature: _____ Print Name:_____ Date: ____/____/20____