



# HammondCare

## SPECIALIST PALLIATIVE & SUPPORTIVE CARE SERVICE REFERRAL FORM NORTH

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DOB	M.O	
ADDRESS		
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Referral to :  PALLIATIVE CARE INPATIENT UNIT  COMMUNITY PALLIATIVE CARE SERVICE  
 ATTENTION:  Dr Bridget Johnson (Greenwich)  Dr Sarah Thompson (Neringah)  
 Dr Phil Macaulay (Northern Beaches)

Referrer's Name : \_\_\_\_\_  
 Referrer's contact no: \_\_\_\_\_  
 Referral's Facility: \_\_\_\_\_  
 On behalf of Dr: \_\_\_\_\_  
 Dr's Provider no: \_\_\_\_\_  
 GP name (if not referring doctor): \_\_\_\_\_  
 Practice name: \_\_\_\_\_  
 GP Phone no: \_\_\_\_\_  
 Is GP aware of referral?  Yes  No

Patient location: \_\_\_\_\_  
 Consent to referral?  Patient  Family  
 Person responsible: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone no: \_\_\_\_\_  
 Name of palliative care consultant: \_\_\_\_\_  
 Medicare no: \_\_\_\_\_  
 Health fund name: \_\_\_\_\_ No: \_\_\_\_\_  
 Language: \_\_\_\_\_ Lives alone?  Yes  No  
 Interpreter needed?  Yes  No

Reason for referral (select one or more if applicable):  
 Symptom control  Terminal care  Psychosocial support  Supportive care

Diagnosis and treatment (previous & current):

Medical history:

NSW Health Resuscitation Plan completed? (Please attach to this form)  Yes  No

Relevant additional documents not available on eMR attached  Yes  No  N/A

Infection status and location:

Special instructions (tracheostomy, wound care, CVADs, PEG, modified diet needs):

Falls risk / behavioural concerns:

Functional status:  Independent  Partial assist  Full assist

Skin integrity: \_\_\_\_\_ Waterlow score: \_\_\_\_\_

Patient and family concerns: \_\_\_\_\_  
 Understanding of disease: \_\_\_\_\_  
 Goals of care: \_\_\_\_\_  
 Spiritual / cultural needs: \_\_\_\_\_

Referring doctor's signature:

Date:

**PLEASE FAX COMPLETED REFERRAL TO:**

Greenwich Hospital Inpatient Unit Ph: 9903 8227 Fax: 9903 8100  
 Neringah Hospital Inpatient Unit Ph: 9488 2200 Fax: 9487 1599  
 Palliative Care Community North : Ph: 1800 427 255 Fax: 9903 8265  
*(For urgent referrals please phone the relevant number above)*