|  |  |  |  |
| --- | --- | --- | --- |
| **Client Details** | | **Referrer Details** | |
| **Full Name:** |  | **Referrer Name:** |  |
| **Address:** |  | **Facility/Service:** |  |
| **Phone:** |  |
| **Mobile Ph:** |  | **Site of Pt at Referral:** | Home  Hosp Aged Care |
| **Home Ph:** |  | **Estimated Discharge:** |  |
| **Date of Birth:** |  | **L.M.O/GP Details** | |
| **Gender:** | Male  Female  Non-Binary | **LMO/GP Name:** |  |
| **Aboriginal/TSI:** | Yes  No  Unknown | **Address:** |  |
| **Country of Birth:** |  |
| **Language Spoken:** |  | **Phone:** |  |
| **Needs Interpreter:** | Yes  No  Unknown | **Fax:** |  |
| **Religion:** |  | **Aware of Referral** | Yes  No  Unknown |
| **Medicare Number:** |  | **Specialist Details** | |
| **Ambulance:** | Yes  No  Unknown | **Name:** |  |
| **DVA Care:** | Yes  No  Unknown | **Field:** |  |
| **Advance Care Directive:** | Yes  No  Unknown | **Hospital/Clinic:** |  |
| **Med Treatment Decision Maker:** | Yes  No  Unknown | **Phone:** |  |
| **Primary Carer Details** | |  | |
| **Name:** |  | **Name:** |  |
| **Relationship:** |  | **Field:** |  |
| **Address:** |  | **Hospital/Clinic:** |  |
| **Phone:** |  | **Phone:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please Attach to Fax and Tick:** | | **Discharge Summary** | | | | | | |  | **Specialist Correspondence** | | | | | | |  | |
| **Pathology** | | | | | | |  | **Radiology** | | | | | | |  | |
| **Medication List** | | | | | | |  | **Allergies/Alerts** | | | | | | |  | |
| **Advance Care Directive** | | | | | | |  | **Medical Treatment Decision Maker** | | | | | | |  | |
| **Other Services in Place/Referred:** | | **District Nursing** | | | | | | |  | **Complex Care** | | | | | | |  | |
| **Hospital In The Home** | | | | | | |  | **Post-Acute Care** | | | | | | |  | |
| **Home Help** | | | | | | |  | **Aged Care Assessment Service (ACAS)** | | | | | | |  | |
| **Loddon Mallee Regional Specialist Palliative Care Consultancy Service:** | | | | | | | | | | | | | | |  | |
| **Allied Health Assessment/Input:** | | **Occupational Therapist** | | | | | | |  | **Physiotherapy** | | | | | | |  | |
| **Speech Pathology** | | | | | | |  | **Social Work** | | | | | | |  | |
| **Dietician** | | | | | | |  | **Other** | | | | | | |  | |
| **Diagnosis:** | |  | | | | | | | | | | | | | | | |
| **Date of Diagnosis:** | |  | | | | | | | | | | | | | | | |
| **Current treatments:** | | Chemo/Immunotherapy  Radiotherapy  Chronic Disease Management | | | | | | | | | | | | | | | |
| **Relevant Medical History:** | |  | | | | | | | | | | | | | | | |
| **Reason for Referral to Specialist Palliative Care Service:** Support of Terminal Care, Psychosocial Support, Symptom Control, Resi Aged Care – Complex Symptom Management | |  | | | | | | | | | | | | | | | |
| **Psychosocial:**  ***(Include Social/Living Arrangements/Cultural/ Spiritual Care Needs)*** | |  | | | | | | | | | | | | | | | |
| **Preferred Place of Death** | | Home  In Hospital  Residential Aged Care  Unknown/Not Discussed | | | | | | | | | | | | | | | |
| **Client Aware of Referral and Consents** | | | | Yes  No | | | **Carer Aware of Referral and Consents** | | | | | | | Yes  No | | | |
| **Client Aware of Diagnosis** | | | | Yes  No | | | **Carer Aware of Diagnosis** | | | | | | | Yes  No | | | |
| **Client Insight to Prognosis** | | | Good  Poor | | | | **Carer Insight to Prognosis** | | | | | | Good  Poor | | | | |
| **Palliative Care Phase** *(Tick)* | | | | | | | | | | | | | | | | | |
| *Symptoms are adequately controlled by established management* | | | | | | | | | | | | **Stable** | |  | | | |
| *Development of a new problem or a rapid increase in the severity of existing problems* | | | | | | | | | | | | **Unstable** | |  | | | |
| *Gradual worsening of existing symptoms or the development of new but expected problems* | | | | | | | | | | | | **Deteriorating** | |  | | | |
| *Death likely in a matter of day* | | | | | | | | | | | | **Terminal** | |  | | | |
| **Australian-Modified Karnofsky Performance Status *(AKPS) Scale*** *(Tick)* | | | | | | | | | | | | | | | | | |
| **100** | **Normal, no complaints or evidence of disease** | | | | | | | | | | | | | |  | | |
| **90** | **Able to carry on normal activity, minor signs or activity** | | | | | | | | | | | | | |  | | |
| **80** | **Normal activity with effort, some signs or symptoms of disease** | | | | | | | | | | | | | |  | | |
| **70** | **Care for self, unable to carry on normal activity or to do active work** | | | | | | | | | | | | | |  | | |
| **60** | **Occasional assistance but is able to care for most needs** | | | | | | | | | | | | | |  | | |
| **50** | **Requires considerable assistance and frequent medical care** | | | | | | | | | | | | | |  | | |
| **40** | **In bed more that 50% of the time** | | | | | | | | | | | | | |  | | |
| **30** | **Almost completely bedfast** | | | | | | | | | | | | | |  | | |
| **20** | **Totally bedfast & requiring nursing care by professionals and/or family** | | | | | | | | | | | | | |  | | |
| **10** | **Comatose or barely rousable** | | | | | | | | | | | | | |  | | |
| **Palliative Care Symptoms** *(Rate 0-3)* | | | | | | | | | | | | | | | | | |
| **Palliative Care Problem Severity Score Clinician Rated 0 = Absent 1 = Mild 2 = Moderate 3 = Severe** | | Pain | | |  | | | | Breathing | | | | |  | | | |
| Nausea | | |  | | | | Fatigue | | | | |  | | | |
| Appetite | | |  | | | | Difficulty Sleeping | | | | |  | | | |
| Bowels | | |  | | | | Anxiety | | | | |  | | | |
| Other: | | |  | | | |  | | | | |  | | | |
| **Palliative Care Considerations** *(Tick)* | | | | | | **Nil** | | **Unknown** | | | **Mild** | | **Moderate** | | | **Severe** | |
| **Physical suffering or distress of patient** | | | | | |  | |  | | |  | |  | | |  | |
| **Psychological or spiritual suffering or distress of patient** | | | | | |  | |  | | |  | |  | | |  | |
| **Distress or burnout of carer** | | | | | |  | |  | | |  | |  | | |  | |
| **Urgent and complex communication or information needs of patient or care giver** | | | | | |  | |  | | |  | |  | | |  | |
| **Significant discrepancy between care needs and care arrangements** | | | | | |  | |  | | |  | |  | | |  | |
| **Mismatch between current site of care and patient or caregivers desired site of care** | | | | | |  | |  | | |  | |  | | |  | |
| **Patient is imminently dying** | | | | | |  | |  | | |  | |  | | |  | |
| **Palliative Care Emergencies for Consideration** | | | | | | | | | | | | | | | | | |
| Suspected/Impending Spinal Cord Compression, Superior Vena-Cava Obstruction, Airway Obstruction, Seizures or Acute Bleeding. Please seek guidance from Medical Specialist | | | | | | | | | | | | | | | | | |
| **Referrer Signature: Date:** | | | | | | | | | | | | | | | | | |