|  |  |
| --- | --- |
| **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:** |