



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

Facility:

COMMUNITY PALLIATIVE CARE SERVICES REFERRAL FORM

Referral Guidelines

1. Please complete all sections of this form and return to Central Referral Service via email to **WSLHD-CommunityHealth-ReferralService@health.nsw.gov.au**
2. Alternatively, referrals can be faxed to **9881 7789**.
3. Sections marked with an asterisk (*) are mandatory fields.
4. For enquiries, please phone **1800 600 681**.
5. **Community Health does not accept referrals for clients aged under 16 years of age or individuals residing in a correctional centre at the time when intervention is required.**
6. Community Palliative Care provides services for clients who are 16 years of age or above and have a life limiting illness with no expectation of recovery.

Client Information

Client Name*:		
Address*:		
Suburb*:		Postcode*:
Medicare No.*:	Date of Birth*:	Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/> Other:
Home Phone*:		Mobile Phone:
Email:		
Has the client consented to this referral*: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:		
Is the client Aboriginal or Torres Strait Islander*?	<input type="checkbox"/> Yes - Aboriginal <input type="checkbox"/> Yes - Torres Strait Islander <input type="checkbox"/> Yes - Aboriginal and Torres Strait Islander	<input type="checkbox"/> No to either <input type="checkbox"/> Declined to respond

Reason for Referral

Nursing Referral Please select all relevant options*.	<input type="checkbox"/> Symptom Management Clients experiencing exacerbation of symptoms associated with life limiting illnesses/disease (i.e., breathlessness, pain, constipation)		
	<input type="checkbox"/> Psychosocial Support Clients identified as having complex social concerns (i.e., living alone, frail, lacking social network/support).		
Allied Health Referral Please select all relevant options*.	<input type="checkbox"/> Carer's Support Carers identified as needing assistance and support with caring for a loved one during the palliative care process.		
	<input type="checkbox"/> Physical Support Identifying issues with physical activities and facilitate referrals to appropriate disciplines. Elements of carer training may also be provided.		
	<input type="checkbox"/> Treatment Support Clients already undergoing treatment to support palliative care symptom management.		
	<input type="checkbox"/> Link Up Clients requiring initial touch points with the service prior to disease progression.		
	<input type="checkbox"/> RACF in Reach Clients requiring support who are residing at a Residential Aged Care Facility		
	<input type="checkbox"/> Speech Pathology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Not required <input type="checkbox"/> Social Work <input type="checkbox"/> Podiatry <input type="checkbox"/> Dietetics		
Please provide details on the reason for referral*.	Introduction		
	Situation		
	Background		
	Assessment		
	Recommendation		
	Other		
Patient's Condition* (select 1 option)	<input type="checkbox"/> Acute/Unstable <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Terminal	ECOG Performance Status* (select 1 option)	<input type="checkbox"/> 0 Fully Active <input type="checkbox"/> 1 Restricted in physical strenuous activity but ambulatory and able to carry out light work. <input type="checkbox"/> 2 Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours. <input type="checkbox"/> 3 Capable of only limited self care, confined to bed or chair more than 50% of waking hours. <input type="checkbox"/> 4 Completely disabled. Cannot carry out any self-care.



Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

WSHR-0217 230724

NO WRITING



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D.O.B. ____/____/____	M.O.	
ADDRESS		
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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

**COMMUNITY PALLIATIVE CARE
SERVICES REFERRAL FORM**

Service requested to commence	Date:
Country of Birth*:	
Interpreter required*: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Language/Dialect (Mandatory if 'Yes' selected for interpreter):

Safety and Risks

Detail any safety concerns and/or identified risks for the clinician during service provision (e.g., behavioural, aggression, pets):

Living Arrangements

Type of Accommodation:	Other:
Does the client live alone*: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Carer Details

Does the client have a carer*? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who is their carer? (Full Name)
Carer's Contact Details*:	Carer's Residency Status: <input type="checkbox"/> Resident <input type="checkbox"/> Non-Resident
Language spoken:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does Carer / Contact person need to be present at assessment*? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the carer the person to contact for the client? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, who is the person to contact	Full Name: Address: Phone:

Care responsibilities

Is the client a carer*? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who do they care for? (Full name)
Their date of birth:	Relationship:

GP Details*

Name: Fax: Practice Name & Address:	Telephone Email:
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Consultant Details*

Is the patient known to the WSLHD Supportive and Palliative Care Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Supportive and Palliative Care Physician: Practice Name & Address:	Telephone: Fax: Email:

Other Specialist Consultant Details

Name: Fax: Practice Name & Address:	Telephone: Email:
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Referrer Details *

Referral Date:	Referrer Name
Referrer Phone:	Referrer Organisation: (if a hospital please state ward: _____)
Referrer Email:	

OFFICE USE ONLY:

Date received:	Date reviewed:
Actioned By:	

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