Western Sydney Local Health District

NSW GOVERNMENT

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

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*: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose ☐ Other:
Home Phone*:	Mobile Phone:	
Email:		
Has the client consented to this referral*: ☐ Yes ☐ No ☐ Other:		

Is the client Aboriginal or Torres Strait Islander*?	☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander	☐ No to either ☐ Declined to respond

Reason for Referral

Nursing Referral

Please select all relevant options*.

- ☐ Symptom Management
  Clients experiencing exacerbation of symptoms associated with life limiting illnesses/disease (i.e., breathlessness, pain, constipation)
- ☐ Psychosocial Support
  Clients identified as having complex social concerns (i.e., living alone, frail, lacking social network/support).
- ☐ Carer's Support
  Carers identified as needing assistance and support with caring for a loved one during the palliative care process.
- ☐ Physical Support
  Identifying issues with physical activities and facilitate referrals to appropriate disciplines. Elements of carer training may also be provided.
- ☐ Treatment Support
  Clients already undergoing treatment to support palliative care symptom management.
- ☐ Link Up
  Clients requiring initial touch points with the service prior to disease progression.
- ☐ RACF in Reach
  Clients requiring support who are residing at a Residential Aged Care Facility

Allied Health Referral

Please select all relevant options*.

☐ Speech Pathology ☐ Occupational Therapy ☐ Physiotherapy ☐ Dietetics
☐ Social Work ☐ Podiatry ☐ Clinical Psychology ☐ Not required

Please provide details on the reason for referral*.

Introduction
Situation
Background
Assessment
Recommendation
Other

Patient's Condition* (select 1 option)	☐ Acute/Unstable ☐ Stable ☐ Deteriorating ☐ Terminal	ECOG Performance Status* (select 1 option)	☐ 0 Fully Active ☐ 1 Restricted in physical strenuous activity but ambulatory and able to carry out light work. ☐ 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. ☐ 3 Capable of only limited self care, confined to bed or chair more than 50% of waking hours. ☐ 4 Completely disabled. Cannot carry out any self-care.

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Service requested to commence	Date:
Country of Birth*:	
Interpreter required*: ☐ Yes ☐ 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: Click arrow to select OR fill "Other" field Other:

Does the client live alone*: ☐ Yes ☐ No

Carer Details

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

Care responsibilities

Is the client a carer*? ☐ Yes ☐ No	If yes, who do they care for? (Full name)
Their date of birth:	Relationship:

GP Details*

Name: Fax: Practice Name & Address:	Telephone Email:

Consultant Details*

Is the patient known to the WSLHD Supportive and Palliative Care Services?	☐ Yes ☐ 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:

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:	

NO WRITING