Queensland Government

Gold Coast Health

SUPPORTIVE AND SPECIALIST PALLIATIVE CARE SERVICE ASSESSMENT REFERRAL

Please complete all sections of this form and fax referral to 56686759 or email GC_PalCare_Referral@health.qld.gov.au

This form and the attached referral may be completed by any clinician but must be signed by a Doctor or Nurse Practitioner

The below information MUST be provided- failure to do so will delay actioning of the referral and a request for further information will be sent back to the referrer prior to the referral being processed.

The role of the Supportive & Specialist Palliative Care (SSPCS) is to assist in patient care. We do not take over clinical care from the GP whom we consider to be the centre of medical care in the community.

Referral from:____

Contact Details:____

Date:____

Please include the following information:

- ☐ Patient details
- ☐ Medicare number /expiry date
- ☐ NOK /contact / address details
- ☐ GP contact details
- ☐ Current medication and allergy list
- ☐ Recent investigations
- ☐ Specialist correspondence
- ☐ Relevant Radiology Results
- ☐ Relevant Laboratory Results
- ☐ Please attach copies of any of the following (EPOA, AHD, ARP, Statement of choices)

Kind Regards,

Community Palliative Care

Queensland Government

Gold Coast Health

SUPPORTIVE AND SPECIALIST PALLIATIVE CARE SERVICE REFERRAL

Attention: Dr. Andrew Broadbent

Please ensure ALL details are completed -failure to do so will delay actioning of the referral and it will be returned to referrer for completion . Thank you

Patient Details: Surname ________________________ **First name** _____________________________

Street Address ____ **Suburb** _______________________

State ___________________ **Postcode** ___________ **DOB** _ _ / _ _ / _ _ _ _

Phone _________________ **Mobile** ____________________ **Email** ____________________________________

Next of Kin / Carer Details

Name ____________________________________ **Relationship** ____

Phone ________________ **Mobile** _____________________

Referral Location: ☐ Private Hospital _______________________ ☐ Other __________________

Referring GP/Consultant/Specialist : ____

Referrer contact details: ____

GP Details: Name: ______________________________ **Phone:** _____________________

Is the patient/family aware of this referral, their condition and their diagnosis? ☐ **Yes** ☐ **No**

Is the client an inpatient? ☐ **Yes** ☐ **No** **Ward/Clinic**_______________________ **Discharge date:**______/______/______

REFERRAL FOR: ☐ Transfer of care/Admission ☐ Consultation Liaison ☐ Community and OPD

☐ Other :

URGENCY:

☐ Non Urgent – Please email/fax referral **GC_PalCare_Referral@health.qld.gov.au OR Fax to (07) 5668 6759**

☐ Urgent Inpatient (Hours/days) –**GCUH 0402 969 687 or Robina 0439 826 857**

☐ Urgent Community (Hours/days) – **1300 763 218**

PRIMARY DIAGNOSIS (principal life-limiting illness)

Estimated Prognosis: ☐ Days ☐ Weeks ☐ Months ☐ Years

Malignant:			
☐ Bone and soft tissue	☐ Gynaecological	☐ Pancreas	☐ Other GIT
☐ Breast	☐ Haematological	☐ Prostate	☐ Other Urological
☐ CNS	☐ Head and Neck	☐ Skin	☐ Other Malignancy
☐ Colorectal	☐ Lung	☐ Unknown Primary	☐ Location Metastases _____________________

Non Malignant:

☐ Cardiovascular disease
☐ HIV / AIDS
☐ End stage kidney disease
☐ Stroke
☐ Motor neurone disease

☐ Alzheimer's disease
☐ Other dementia
☐ Oher neurological disease
☐ Respiratory failure
☐ End stage liver disease

☐ Diabetes and its complications
☐ Sepsis
☐ Multiple organ failure
☐ Other non-malignancy

☐ Advanced Care Plan completed	☐ yes	☐ no
☐ Enduring Power of Attorney completed	☐ yes	☐ no
☐ Statement of Choices	☐ yes	☐ no

Symptoms and / or concerns for nursing /medical review:

☐ Nausea / Vomiting	☐ Pain	☐ Psychosocial	☐ Functional /fatigue
☐ Dyspnoea	☐ Bowel problems	☐ Anxiety	☐ Family/ Carer support
☐ Counselling	☐ Spiritual	☐ Neurological	☐ Advice for discharge planning

☐ Terminal Care (patient in the last hours /days of life) – please phone through immediately

☐ Specialist Allied Health review

☐ Pharmacy ☐ Social Worker ☐ Occupational Therapy

☐ Physiotherapy ☐ Psychologist ☐ Other ________________________________

Ongoing Treatment plan:

Has the management of acute deterioration been discussed	☐ yes	☐ no
Does the patient want blood transfusions if clinically indicated	☐ yes	☐ no
Are parental fluids medically appropriate if clinically indicated	☐ yes	☐ no
Does the patient want hospital admission if they deteriorate	☐ yes	☐ no

Should the patient be transferred to an acute hospital for:

1.	AMI	☐ yes	☐ no
2.	Fracture	☐ yes	☐ no
3.	Pneumonia	☐ yes	☐ no
4.	Stroke	☐ yes	☐ no
5.	Other	☐ yes	☐ no

Additional Details:

Name of Doctor / Nurse Practitioner: **Provider Number**

Signature: **Date:**