



Community Supportive &
Palliative Care Referral

MRN		SURNAME	
GIVEN NAME(S)			
DOB	GENDER	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

New Referral Re-referral Date: ___/___/___

**If referral is urgent, or if you have questions,
please call the Community Palliative Care Triage Nurse on +61 8382 9444**

Does the patient have a life limiting condition? Yes No

Has the patient consented to this referral? Yes No

REASON FOR REFERRAL

<input type="checkbox"/> Complex symptom management	<input type="checkbox"/> Complex psychosocial/allied health support needs
<input type="checkbox"/> End of life care	<input type="checkbox"/> Supportive care during cancer treatment

Is the patient able to attend an outpatient clinic? Yes No

Date:	Hospital / Practice:
Referred by:	Referrer Phone:
Position:	Provider No.: <i>(if applicable)</i>
Patient Phone:	Patient Mobile:
Patient Email:	
Country of Birth:	Identifies as: <input type="checkbox"/> Aboriginal and/or <input type="checkbox"/> Torres Strait Islander
Medicare Number:	Religion:
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Language & Dialect:
Marital Status:	Work Cover/Dust Diseases:
Health Fund/DVA status.:	Policy No.:

MAIN DIAGNOSIS

SECONDARY DIAGNOSIS

ADDITIONAL COMMENTS: *(Main concerns, current and proposed treatment)*



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NEXT OF KIN / PERSON RESPONSIBLE

Name:	Relationship with patient:
Address:	
Phone:	Mobile:
Email:	

CARER DETAILS Same as Next of Kin? Yes No (If No, please complete)

Name:	Relationship with patient:
Address:	
Phone:	Mobile:
Email:	

INITIAL PERSON TO CONTACT

<input type="checkbox"/> Patient	<input type="checkbox"/> Next of Kin/Person Responsible
<input type="checkbox"/> Carer	<input type="checkbox"/> Other:

SAFETY / SECURITY CONCERNS: (Please tick all that apply)

<input type="checkbox"/> History of verbal/physical aggression	<input type="checkbox"/> Animals posing risk:
<input type="checkbox"/> History of drug/alcohol abuse	<input type="checkbox"/> Infection/cytotoxic risk:
<input type="checkbox"/> Behavioural Concerns	<input type="checkbox"/> Other:

GENERAL PRACTITIONER & SPECIALISTS DETAILS: (List all relevant)

GP aware of referral? Yes No Don't know

Name:	Address:	Phone:	Fax:	Email:
GP:				

PLEASE ATTACH ANY OF THE FOLLOWING (Additional information can also be faxed to 02 8382 9585)

<input type="checkbox"/> Medical History record MUST be attached	<input type="checkbox"/> Discharge Summaries
<input type="checkbox"/> Current Medication list	<input type="checkbox"/> Specialists' Correspondence
<input type="checkbox"/> Advance Care Plan / Directive	<input type="checkbox"/> Recent investigations

Please email completed form to: cpct.referrals@svha.org.au
Please use file & email subject line: **Community Referral [Patient Surname] [DOB DD/MM/YYYY]**