



Community Supportive & Palliative Care Referral

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Date: ___/___/___

New Referral

Re referral

For urgent referrals and any questions please contact the Community Triage Nurse on (02) 8382 9444.

If the patient can attend an outpatient clinic please contact (02) 8382 9435.

ALL REFERRALS MUST BE SIGNED BY THE REFERRING MEDICAL PRACTITIONER FOR MEDICARE PURPOSES

REFERRAL CRITERIA: 1: Progressive end stage life limiting condition
 2: Patient consents to this referral

REASON FOR REFERRAL

Complex pain or symptom management End of life care

Complex psychosocial/allied health support needs

Select either: Is the patient able to attend an outpatient clinic? OR Do they need a home visit?

Referring Doctor: Referrer Phone:

Hospital/Practice: Position:

Referring Practitioner Signature: Provider No.:

Patient Address:

Patient Phone: Patient Mobile:

Patient Email:

Country of Birth: Identifies as: Aboriginal and/or Torres Strait Islander

Medicare Number: Religion:

Interpreter Required: Yes 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) then complete page 2 (see over)



SH0000110

BINDING MARGIN - NO WRITING
St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

COMMUNITY SUPPORTIVE & PALLIATIVE CARE REFERRAL

SH110



**Community Supportive &
Palliative Care Referral**

MRN	SURNAME		
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

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)

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"/> Relevent 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]**

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