SACRED HEART HEALTH SERVICE

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)*

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

COMMUNITY SUPPORTIVE & PALLIATIVE CARE REFERRAL

SH110

SACRED HEART HEALTH SERVICE

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

☐ Patient	☐ Next of Kin/Person Responsible
☐ Carer	☐ Other:

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

☐ History of verbal/physical aggression	☐ Animals posing risk:
☐ History of drug/alcohol abuse	☐ Infection/cytotoxic risk:
☐ Behavioural Concerns	☐ 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)*

☐ Medical History record **MUST** be attached	☐ Discharge Summaries
☐ Current Medication list	☐ Specialists' Correspondence
☐ Advance Care Plan / Directive	☐ 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]

NO WRITING