Palliative Care Referral Triage and Transfer Form

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Does the person identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No AHLO contacted? ☐ Yes ☐ No

Patient living alone: ☐ Yes ☐ No Carer Support ☐ Yes ☐ No Remote Area ☐ Yes ☐ No

General Practitioner: _____ Available for home Visits: ☐ Yes ☐ No ☐ Unsure

Contact phone No: _____ Contact by phone A/h: ☐ Yes ☐ No ☐ Unsure

Main Carer: _____ Relationship: _____ Phone No: _____

Address (if different to patient): _____

_____

Does the patient have *(tick)*	**Who/Where**	**Dated**
☐ Not for Resuscitation Order		
☐ Limitation of Medical Treatment		
☐ Advance Care directive /Goals of care form		
☐ Advance Care Plan		
☐ Medical treatment decision maker		

Estimated prognosis (tick one) ☐ Day ☐ Weeks ☐ Months ☐ 6-12 months

Discussion with patient regarding ☐ diagnosis ☐ prognosis ☐ benefit of referral to palliative care

Discussion with family /carer regarding ☐ diagnosis ☐ prognosis ☐ benefit of referral to palliative care

Patient has consent for referral to:

- ☐ Community based service: Email district.nursing@basscoasthealth.org.au Fax: 56785183
- ☐ Inpatient unit / hospital admission
- ☐ Residential Aged Care
- ☐ Palliative Care Outpatient Clinic
- ☐ Respite Services
- ☐ Specialist Palliative Care consultancy service (for complex physical and psychosocial palliative care needs Ph: LRH 5173 8713)

Urgency of Referral

- ☐ 24 Hours; (urgent; patient unstable, rapidly deteriorating or is in the terminal/dying phase)
- ☐ Two working days; (patient experiencing distress physical and/or psychosocial symptoms not responding to established palliative care management/protocols)
- ☐ One week; (patient stable but seeking palliative care information and support)
- ☐ Is an inpatient; (considering transfer to community palliative care)

Main diagnosis, relevant history and management (please attach copies of recent medical correspondence, recent screening / imaging and blood tests

_____

_____

_____

_____

_____

_____

_____

_____

What is the trigger for palliative care referral ?

☐ 1. Symptom assessment and management ☐ 2. Terminal Phase ☐ 3. Respite Care

Details: _____

_____

_____

PALLIATIVE CARE REFERRAL TRIAGE AND TRANSFER FORM

MR/895

BCH3895

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ALERTS including known allergies / medication sensitivities / cytotoxic precautions

_____

_____

_____

Current medications, dose route frequency time of last medication review (if known)

_____

_____

_____

Any other relevant information include family issues dynamics, cultural needs and any concern about carer

_____

_____

_____

Home Help Services (tick if in place)

☐ Home Help ☐ Property maintenance ☐ Carer Services ☐ ACAS Assessment ☐ Other: _____

Problem Severity Score Clinician rated 0=Absent, 1=mild, 2=moderate, 3=severe Please apply number to relevant symptoms	
Difficulty sleeping	
Appetite problems	
Nausea	
Bowel problems	
Breathing problems	
Fatigue	
Pain	
Psychological/ spiritual	
Family/carer	
Other	

Phase of illness-definitions according to Palliative Care outcomes Collaborative (PCOC) Clinician rated (tick one)

- ☐ Phase 1: Stable Symptoms are adequately controlled by established management
- ☐ Phase 2: Unstable Development of a new problem or a rapid increase in the severity of existing problems
- ☐ Phase 3: Deteriorating Gradual worsening of existing symptoms or the development of new but expected problems
- ☐ Phase 4: Terminal Death likely in a matter of days
- ☐ Phase 5: Bereaved Death of a patient has occurred and the carers are grieving

Australian modified Karnofsky Performance Scale (AKPS) (tick one)

- ☐ 100 Normal, no complaints or evidence of disease
- ☐ 90 Able to carry on normal activity, minor signs of illness present
- ☐ 80 Normal activity with effort, some signs or symptoms of disease
- ☐ 70 Able to care for self, but unable to work or carry on other normal activities
- ☐ 60 Able to care for most needs but requires occasional assistance
- ☐ 50 Considerable assistance and frequent medical care required
- ☐ 40 In bed more than 50% of the time
- ☐ 30 Almost completely bedfast
- ☐ 20 Totally bedfast & requiring nursing care by professionals and/or family
- ☐ 10 Comatose, or barely rousable
- ☐ 0 Death

Other Comments: _____

_____

Referred by

☐ Nurse ☐ Consultant ☐ Hospital ☐ Community Health Centre ☐ GP ☐ Other: _____

Name: _____ Name of Organisation: _____

Date: _____/_____/_____

Name of Nurse receiving: _____ Signature: _____

Designation: _____ Date: _____/_____/_____

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