



BCH
Bass Coast Health

Palliative Care Referral Triage and Transfer Form

Surname U.R. No.
 First Name Gender
 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
<input type="checkbox"/> Not for Resuscitation Order		
<input type="checkbox"/> Limitation of Medical Treatment		
<input type="checkbox"/> Advance Care directive /Goals of care form		
<input type="checkbox"/> Advance Care Plan		
<input type="checkbox"/> 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:	Urgency of Referral
<input type="checkbox"/> Palliative Care Specialist Outpatient Clinic <input type="checkbox"/> Community-based Service <i>If referred to above options, please email: district.nursing@basscoasthealth.org.au</i> <i>If referral is considered urgent please also phone District Nursing on (03) 5671 9219</i>	<input type="checkbox"/> 24 Hours; (urgent; patient unstable, rapidly deteriorating or is in the terminal/dying phase) <input type="checkbox"/> Two working days; (patient experiencing distress physical and/or psychosocial symptoms not responding to established palliative care management/protocols) <input type="checkbox"/> One week; (patient stable but seeking palliative care information and support) <input type="checkbox"/> Is an inpatient; (considering transfer to community palliative care)
<input type="checkbox"/> Inpatient unit / Hospital admission <input type="checkbox"/> Residential Aged 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/316





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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	Phase of illness-definitions according to Palliative Care outcomes Collaborative (PCOC) Clinician rated (tick one)	Australian modified Karnofsky Performance Scale (AKPS) (tick one)
Difficulty sleeping	<input type="checkbox"/> Phase 1: Stable Symptoms are adequately controlled by established management <input type="checkbox"/> Phase 2: Unstable Development of a new problem or a rapid increase in the severity of existing problems <input type="checkbox"/> Phase 3: Deteriorating Gradual worsening of existing symptoms or the development of new but expected problems <input type="checkbox"/> Phase 4: Terminal Death likely in a matter of days <input type="checkbox"/> Phase 5: Bereaved Death of a patient has occurred and the carers are grieving	<input type="checkbox"/> 100 Normal, no complaints or evidence of disease
Appetite problems		<input type="checkbox"/> 90 Able to carry on normal activity, minor signs of illness present
Nausea		<input type="checkbox"/> 80 Normal activity with effort, some signs or symptoms of disease
Bowel problems		<input type="checkbox"/> 70 Able to care for self, but unable to work or carry on other normal activities
Breathing problems		<input type="checkbox"/> 60 Able to care for most needs but requires occasional assistance
Fatigue		<input type="checkbox"/> 50 Considerable assistance and frequent medical care required
Pain		<input type="checkbox"/> 40 In bed more than 50% of the time
Psychological/ spiritual		<input type="checkbox"/> 30 Almost completely bedfast
Family/carers		<input type="checkbox"/> 20 Totally bedfast & requiring nursing care by professionals and/or family
Other	<input type="checkbox"/> 10 Comatose, or barely rousable	
		<input type="checkbox"/> 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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