Calvary

PALLIATIVE HOME CARE REFERRAL

Health Care South Australia

Unit Record Number _____

Family Name _____

Given Names _____

Address _____

Phone _____

Date of Birth | | | | | | | | | Age | |

Sex | | Room No. _____ OR USE LABEL

The Calvary Palliative Home Care team will aim to ensure patients receive the best care in the most suitable location whilst honouring their desires and in consideration of their care needs. This service is funded through private health insurance.

Criteria for eligibility and a guide for referral to this service:

- ☐ Patient has a progressive, life limiting illness.
- ☐ Patient or their decision maker is aware of, understands and has agreed to a palliative care referral.
- ☐ Primary goals of patient care are to manage symptoms, maximise function, maintain quality of life and provide comfort.
- ☐ Patient has appropriate private health insurance. Health fund details will be required prior to acceptance of referral.

Patient Information

Private Health Insurer	Private Health Membership No:
☐ Lives alone	☐ Interpreter required / Language

Primary Contact / Substitute Decision Maker / Person Responsible *(cross out which does not apply)*

Name	Phone
Relationship	☐ To be present at assessment

Life Limiting Illness

Primary Diagnosis	Date of diagnosis
Metastatic Diagnosis	Date of diagnosis
Drug allergies	Infectious alerts (MRSA, VRE etc)
Comorbidities	

Reasons for referral – please indicate main concerns

☐ Symptom management

☐ Pain ☐ Nausea ☐ Dyspnoea ☐ Neurological ☐ Functional

☐ Psychosocial ☐ Gastrointestinal

☐ Other _____

_____

☐ End of Life care (patient is considered to be in the last weeks of life)

☐ Other Considerations _____

_____

_____

_____

CPHC REFERRAL FORM

MR 8.1

2CNA333 16/10/24 V1.0 • MR/MR8.1/16102024/V1.0

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Patient Information

Please ensure relevant detailed medical letters and results accompany this referral, and indicate attachments below:

☐ Medical correspondence ☐ Pathology results ☐ Current medication list ☐ Radiology results

☐ Advanced Care Directive ☐ Advance Care Plan ☐ Resuscitation Plan – 7 Step Pathway

Comments: _____

Referrer Details – Medical Specialist/GP

Name	Phone
Address	
Signature	

GP Details

☐ Same as referrer

Name	Phone
Adress	

Please forward referrals to Calvary Palliative Home Care:

Fax: 08 8239 9128
Email: sa-cna-pith@calvarycare.org.au
Phone: 08 8239 9511

Voluntary Assisted Dying (VAD)
Calvary does not support, facilitate or have involvement in voluntary assisted dying (VAD).

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