CHCK PALLIATIVE CARE REFERRAL FORM

INPATIENT REFERRAL ☐
REASON FOR REFERRAL

COMMUNITY TEAM ☐
REASON FOR REFERRAL

Calvary Health Care Kogarah

Please check information in eMR with client to ensure up to date e.g. phone number, NOK, temporary address, etc

REFERRER DETAILS			
NAME: **DEPT / HOSPITAL:**		**Telephone: ~~95407111~~**	**~~Pager no. 541~~**
PATIENT DETAILS			
Title	Family Name	First Name	MRN:
Sex M ☐ F☐	Date of Birth: Age:	Medicare No:	
Medicare ☐ Private Health Fund Name: No. DVA: Gold ☐ White ☐			
Street		Suburb Postcode	
Telephone (Home) (Work) (Mobile)			
Country of Birth: Aboriginal ☐ Torres Strait Islander ☐ ATSI ☐		Preferred Language Interpreter Required English	
Interpreter Required Yes ☐ No ☐ Unknown ☐			
CONSULTANT		**GP DETAILS**	
Name Specialty		Name Ph:	Aware of Referral Yes ☐ No ☐
NEXT OF KIN/ PERSON TO CONTACT DETAILS			
Name (PRINT)		Relationship to Client	
Telephone (Home) (Work) (Mobile)			
Address			
REASON FOR ADMISSION:		Phase: RUG:	

Diagnosis /History:

PATIENT ALERTS (Tick the relevant column)	**YES**	**NO**	**UNKNOWN**
Known Multi-resistant Organism: VRE MRSA ESBL HEP	☐	☐	☐
Cytotoxic Medication (e.g. for Cancer, Arthritis, Psoriasis)	☐	☐	☐
CPR FORM UPDATED Date: Pace T1 Clinical Review No CPR	☐	☐	☐
ADVANCED CARE PLAN	☐	☐	☐

BINDING MARGIN - NO WRITING

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Nov 12/Rev 5