COMMUNITY PALLIATIVE CARE TEAM REFERRAL FORM

Calvary Health Care Kogarah

Please return completed form to:
Fax: 02) 9553-3366
Email: SESLHD-Calvary-CPCT@health.nsw.gov.au

FAMILY NAME
GIVEN NAME
D.O.B. _____/_____/_____ ☐ MALE ☐ FEMALE
ADDRESS

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRED BY Name: ..... Designation: .....
Organisation: ..... Location: .....
Phone: ..... Fax: ..... Referring MO: .....
Sign: ..... Date: ..... / ..... / .....

PATIENT DETAILS ❒ Male ❒ Female ❒ Married/De-facto ❒ Widowed ❒ Divorced ❒ Never Married
Indigenous Status: ❒ Aboriginal ❒ Torres Strait Islander ❒ Aboriginal & TSI ❒ Neither
Title: ..... First Name: ..... Last Name: .....
Date of Birth: ..... / ..... / ..... Age: ..... Religion: .....
Address: .....
.....
Patient's Phone No's: H: ..... M: .....
Country of Birth: ..... Preferred Language: ..... Interpreter ❒ Yes ❒ No
DVA Number: ..... Gold Card ❒ Yes ❒ No
Health Fund Name: ..... Number: .....
Pension number: ..... Medicare No: .....

CARER DETAILS
Who should we contact regarding this referral: ❒ Patient ❒ 1st contact
Has the patient consented sharing medical information with the contact person: ❒ Yes ❒ No

1st Contact:	Relationship to patient:
Phone:	Lives with patient? ❒ Yes ❒ No
Carer:	Relationship to patient:
Phone:	Lives with patient? ❒ Yes ❒ No

Does the patient live alone? ❒ Yes ❒ No Is the patient or carer aware of the referral? ❒ Yes ❒ No
Other significant family / social summary: .....
.....
.....

SERVICE PROVIDERS

GP Name:	GP's Phone:
Specialist:	Location:
Specialist:	Location:
Community Nurses: ❒ Yes ❒ No	Other services involved:

Chemotherapy: ❒ Yes ❒ No Location: ..... Doctor: ..... Date: .....
Radiotherapy: ❒ Yes ❒ No Location: ..... Doctor: ..... Date: .....

ADVANCE CARE PLANNING
Has the patient's Resuscitation Status been discussed? ❒ Yes ❒ No
Is there an Advance Care Plan? ❒ Yes ❒ No ❒ Discussed ❒ Unknown *(❒If yes, copy attached)*
Is there an EPOA? ❒ Yes ❒ No ❒ Discussed ❒ Unknown
Please describe the patient's insight into their disease and prognosis: .....
.....

CALVARY HEALTH CARE SYDNEY DO NOT WRITE

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CLINICAL INFORMATION ❒ *Or See Attached Document*

Terminal Diagnosis: .....

Allergies: .....

Other Significant Medical History: .....

.....

.....

Reason for this Referral: .....

.....

.....

MEDICATION: ❒ *See Attached* ❒ *See eMeds*

MOBILITY STATUS:

1. Independently Mobile ❒	4. Mobile with assistance of 1 ❒
2. Mobile with walking aid ❒	5. Mobile with assistance of 2 ❒
3. Mobile with Supervision ❒	6. In bed all of the time ❒

Are there any other Physical needs? ❒ Yes ❒ No

Please describe: : .....

.....

.....

STAFF SAFETY

Are you aware of any potential risks to **Staff Safety** when vitsting at home? ❒ Yes ❒ No

Please describe: .....

.....

PSYCHOSOCIAL

Does the patient or carer demonstrate **emotional or spiritual distress**? ❒ Yes ❒ No

Please describe: .....

.....

.....

Are there any social workers/psychologists/counsellors involved in care? ❒ Yes ❒ No

If yes, please provide details: .....

.....

TRIAGE (CPCT Nurse use only)

Priority: ❒ **Urgent** – visit within 48 hours ❒ **Semi Urgent** – visit within 2 to 3 days

❒ **Not Urgent** – asses within 3 to 5 days (Clinic)

CALVARY HEALTH CARE SYDNEY
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