	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
	D.O.B. ______/______/______	M.O.
Facility: Calvary Health Care Kogarah	ADDRESS	
RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please return completed form to
PO BOX 261, Kogarah NSW 1485
P: 02 9553 3444 F: 02 9588 1635
Email: SESLHD-calvary-kogarahPCNR@health.nsw.gov.au

REFERRED BY

Name: ____ Designation: ______________________________

Organisation: ____

Phone: ____ Fax: ____

Sign: ____ Date: ___________ / ___________/ _____________

Please COMPLETE triage priority

Priority:

☐ **Urgent:** assess within 48 hours. Please phone on 9553-3444

☐ **Semi Urgent:** assess within 2 to 5 days.

☐ Non Urgent: assess within 6 to 13 days.

ALL CRITERIA MUST BE CONSIDERED PRIOR TO SENDING THE REFERRAL
Referral Criteria (All effort should be made to ensure criteria 1 & 2 have been met before sending the referral)

1. **The General Practitioner has agreed to palliative care involvement** ☐
2. **The resident and or family have agreed to a palliative care review** ☐
3. **The resident is imminently dying and requires palliative care review** ☐
4. **The resident has specialist palliative care needs not able to be managed with current plan** ☐
   a. **Poorly controlled symptoms including but not limited to pain, nausea, shortness of breath possibly related to an exacerbation of an existing condition**
   b. **Changes in resident function including increasing falls/reduced mobility, significant weight loss/worsening swallow, increasingly bed bound or an increase in hospital admissions**
   c. **Support and advice needed at a palliative care case conference/family meeting where the resident and/or family are experiencing complex physical/psychological issues OR where there is conflict about goals of care at end of life**

General Practitioner name	
Phone	
Fax	

Please attach copies of (if available):

1. Goals of care discussion Yes ☐
2. Advance care plan Yes ☐
3. Medication chart including PRN medications Yes ☐
4. Latest hospital discharge summary/eMR notes Yes ☐

BINDING MARGIN – NO WRITING

RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL

Health
South Eastern Sydney
Local Health District

FAMILY NAME	MRN
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ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility: Calvary Health Care Kogarah

RESIDENTIAL AGED CARE: PALLIATIVE CARE REFERRAL

Patient Details:

Title:	**First Name:**	**Last Name:**

Facility name and address:

Facility phone number:

M ☐ F ☐	Date of Birth:	Age:	Religion:

Country of Birth?	Language Spoken? Interpreter needed? ☐ Yes ☐ No

Carer Details

1st Contact:	Relationship to patient:

Phone: Home: Work: Mobile:

2nd Contact:	Relationship to patient:

Phone: Home: Work: Mobile:

Clinical Information

Diagnosis:

Reason for referral

What actions have been taken to manage any distress for the resident?

BINDING MARGIN – NO WRITING