MN198

Queensland Government

Metro North Palliative Care Services

PALLIATIVE CARE REFERRAL AND CLINICAL HANDOVER

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Palliative care referral criteria:

☐ Patient/decision maker has consented to referral

☐ Patient has a progressive life-limiting condition ☐ ARP completed (Redcliffe/Community preference)

☐ Patient has a complex symptom or social burden, unresolved by general care

Which service do you require?

☐ Community Palliative Care

☐ **Community Palliative Care – RACF (SPACE)**

☐ Specialist Outpatient appointment

☐ Inpatient Consult (patient's ward:..........)

☐ Palliative Care Unit admission
*(complete form **AND** phone relevant medical team)*

Location:

☐ Redcliffe (Dr Angharad Davies): ph. 3883 7638

☐ RBWH (Dr Alison Kearney): ph. 3646 6138

☐ TPCH (Dr James Stevenson): ph. 3139 4601

☐ Caboolture (Dr Min Min Win): ph. 5316 2433

☐ Community (Dr Bill Lukin): ph. 3049 1210

Referrer's details: ☐ GP ☐ Consultant ☐ Other *(specify)*:..........

Name:.......... Practice / Team:..........

Phone:.......... Fax:.......... Mobile:..........

RACF (SPACE) referral: RACF Facility name:..........

Has the RACF GP been notified & consented to this referral: ☐ Yes- Date of conversation ..../..../....

☐ No – Reason:..........

GP name:.......... GP Phone number:..........

How urgent is it?

☐ Routine

☐ Priority – time frame and reason:..........

☐ Urgent *(complete this form **AND** call PC Dr on-call at relevant service via local switchboard)*

About the patient:..........	Medicare no.:..........
1° diagnosis:..........	2° diagnosis:..........
PCOC scores (if known):..........	Phase:.......... RUG:.......... AKPS:..........

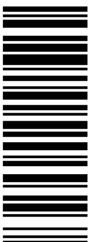
Next of kin	Name:.......... Relationship:.......... Phone:.......... Address:.......... EPOA? ☐ Yes ☐ No Aware of referral to Palliative Care? ☐ Yes ☐ No Required to be present at assessment? ☐ Yes ☐ No
Alternative contact	Name:.......... Phone:..........
Translator required?	☐ Yes *(specify)* ☐ No Language:..........
Accommodation	Lives alone? ☐ Yes ☐ No Access / steps:.......... Detail:..........
Mobility	Ambulant? ☐ Yes ☐ No Can they attend clinic? ☐ Yes ☐ No Aids:..........
Indigenous status	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying

All clinical form creation and amendments must be conducted through Health Information Services

MN198 V4.03 – 03/2023 *Locally printed*



MN198

Queensland Government

Metro North Palliative Care Services

PALLIATIVE CARE REFERRAL AND CLINICAL HANDOVER

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

PALLIATIVE CARE CLINICAL HANDOVER

Reason for referral *(tick all that apply)*	☐ Symptom support ☐ Nausea ☐ GI ☐ Agitation ☐ Pain ☐ Neurological ☐ Dyspnoea ☐ Carer support / psychological issues ☐ Support at end of life ☐ Introduction to service (hospital inpatients) ☐ Other: ....
Provisional prognosis	.... Have you discussed this with the patient? ☐ Yes ☐ No
Medical history / significant comorbidities	.... Does the patient require infectious isolation / precautions? ☐ Yes ☐ No
Allergies *(refer to ieMR)*	....
Alerts *(include known domestic risks)*	.... Constant visual obs required (hospital inpatients)? ☐ Yes ☐ No
Patient's goals of care	.... AHD completed? ☐ Yes ☐ No
Carer status	....
Patient's preferred place of death	....
Agencies / home support engaged *(Include nature & frequency of service/s)*	.... ACAT assessed? ☐ Yes: ...../...../..... ☐ No My Aged Care assessed? ☐ Yes: ...../...../..... ☐ No
Current medications *(Or include current medications list)*	Name / dose / route: | Name / dose / route:

Name: .... Designation: ....

Signature: .... Date: ...../...../.....

Submit form for CPC/CPC-RACF (SPACE):

Fax: 3360 4822 OR email **Central_Referral_Unit@health.qld.gov.au** OR 1300 364 952 MN Outpatient Referrals

For inpatient / PCU referrals: Redcliffe: 3883 7912; TPCH: 3139 4661.

DO NOT WRITE IN THIS BINDING MARGIN