|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referrer Contact details:** | | | | |
| Name and Position: |  | | Organisation: | |
| Phone: | Fax: | Email: | | Date: |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient :** | | | | | | | | | | | |
| Name: | |  | | | | | | Date of birth: | |  | |
| Home Address: | |  | | | | | | | | | |
| Gender: |  |  | | | | ATSI: | | YES |  | NO |  |
| Phone -home: | | | | Mobile: | Patient living alone: | | | YES |  | NO |  |
| **GP:** | | | | | | | | | | | |
| Name: |  | | | | | GP Phone: | |  | | | |
| **Carer:** | | | | | | | | | | | |
| Name: |  | | | | | Relationship: | |  | | | |
| Address (if different to patient address): | | |  | | | | Phone: |  | | | |

|  |  |
| --- | --- |
| Main diagnosis: | Relevant Medical History: |
|  |  |
| **Client alerts:** (cautions, allergies, risk management) | |

|  |
| --- |
| **Current Treatments:** chemotherapy, radiotherapy, other, not applicable |
|  |
|  |
|  |



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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Current symptoms:** physical, psychosocial, other? | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| **Current medications:** (Please add an extra sheet if more information is required) | | | | | | | |
|  | **Doses:** |  | | | **Doses:** | | |
|  |  |  | | |  | | |
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|  |  |  | | |  | | |
| **Anticipated problems that may arise after hours:** | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| **Are anticipatory medication and syringe driver or orders available in the home?** | | | YES |  | | NO |  |

**Planning**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the client want to be cared for at home? | YES |  | NO |  | |
| Is the caregiver managing care at home? | YES |  | NO |  | |
| Does the client want to die at home? | YES |  | NO |  | |
| Does the caregiver want the client to die at home? | YES |  | NO |  | |
| Any specific instructions should client die afterhours? For example, should GP be contacted to complete DOLE? Funeral Service contact? Body bequest arrangements? | | | | | |
|  | | | | | |
| Please advise – does the client have: | | | | | |
| [**Advance Care Directive?**](https://www.advancecareplanning.org.au/resources/advance-care-planning-for-your-state-territory/tas) (please provide copy if available) | YES |  | NO | |  |
| [**Medical Goals of Care?**](https://www.dhhs.tas.gov.au/palliativecare/health_professionals/goals_of_care) (please provide copy if available) | YES |  | NO | |  |

PLEASE COMPLETE THIS REFERRAL AND FAX TO THE PALLIATIVE CARE

**AFTERHOURS PHONE SUPPORT SERVICE: (03) 6273 1788**

For information ***during business*** ***hours***  please contact:

Amanda Sharman GP Assist

Ph: (03) 616 52344

E: amanda.sharman@gpat.com.au

For more information ***after hours*** please contact:

Palliative Care After Hours Phone Support Service - GP Assist

Ph: (03) 6165 2348

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