

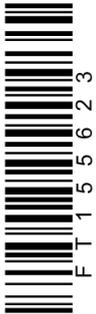
**SPECIALIST PALLIATIVE CARE  
SERVICE REFERRAL**  
STATEWIDE

FACILITY: \_\_\_\_\_

PT ID									
SURNAME..... D.O.B.....									
OTHER NAMES.....									
ADDRESS.....									
.....									

(Tick  as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

Phone number:	Other phone contact:
Client lives alone: <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated discharge date: DD / MM / YYYY
Client's current location:	
<b>Reason for referral – Specialist Palliative Care needs identified</b>	
<input type="checkbox"/> Complex pain and symptom management	<input type="checkbox"/> Complex end of life planning
<input type="checkbox"/> Complex psychosocial and spiritual issues	<input type="checkbox"/> Complex terminal care
<b>Measures initiated to date:</b>	
<b>Diagnosis/relevant history/medications:</b>	
<b>Prognosis (in your opinion): This client has a prognosis of</b> <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	
<b>Is the referral urgent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, phone to discuss</i>	
<b>Attach available information.</b> <input type="checkbox"/> Advance Care Directive <input type="checkbox"/> Medical Goals of Care <input type="checkbox"/> Medication list	
<input type="checkbox"/> Diagnostic information <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Letters	
<b>Identify Primary Health Care Providers involved (complete appropriate referrals)</b>	
<b>Community Health Nurse:</b> <input type="checkbox"/> Referral completed <input type="checkbox"/> Referral discussed	
<b>If over 65 years:</b> <input type="checkbox"/> My Aged Care <input type="checkbox"/> Tasmanian Community Care <input type="checkbox"/> ACAT (Aged Care Assessment Team)	
<b>If under 65 years:</b> <input type="checkbox"/> Tasmanian Community Care	
<input type="checkbox"/> Palliative Care Volunteer <input type="checkbox"/> Respiratory Service for Home Oxygen (O <sub>2</sub> )	
<input type="checkbox"/> Allied Health (specify):	
General Practitioner (print name):	Have they been advised of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Specialist (print name):	Have they been advised of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Primary caregiver (print name):</b>	Relationship to client:
Address:	
Phone number:	Other phone contact:
<b>First contact (print name):</b>	Relationship to client:
Address:	
Phone number:	Other phone contact:
<b>Consent for referral received from:</b> <input type="checkbox"/> Client <input type="checkbox"/> Carer <input type="checkbox"/> Person responsible	
<b>Is client adequately informed about:</b> <input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis	
<b>Referrer (print name):</b>	Designation:
Signature:	Date: DD / MM / YYYY
Phone:	Fax:
<b>Specialist Palliative Care Service – South</b> “Activities Centre” - 90 Davey Street, Hobart Tas 7000 Phone: (03) 6166 2820 Fax: (03) 6173 0303 Email: pcsouth@ths.tas.gov.au	<b>J.W. Whittle Palliative Care Unit</b> 88 Davey Street, Hobart Tas 7000 Phone: (03) 6166 2800 Fax: (03) 6173 0310 Email: whittleward@ths.tas.gov.au
<b>Specialist Palliative Care Centre – North</b> “Allambi Building” 33-39 Howick Street, Launceston Tas 7250 Phone: (03) 6777 4544 Fax: (03) 6777 5253 Email: palliativecare.north@ths.tas.gov.au	<b>Specialist Palliative Care Centre – North West</b> “Parkside” - Level 3, 1 Strahan Street, Burnie Tas 7320 Phone: (03) 6477 7760 Email: palliativecareservicenw@ths.tas.gov.au



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