Metropolitan Palliative Care Consultancy Service (MPaCCS)
REFERRAL FORM

Monday to Friday 8am - 4pm
Phone: 9217 1777
FAX: 9217 1788
Email: MPaCCS@bethesda.org.au
Internet (access referral forms):
www.bethesda.org.au/mpaccs

Name of patient: _____

Date of birth: _____ ☐ Male ☐ Female

Name of facility: _____

Facility phone number: _____

Facility locality: ☐ North ☐ South

REFERRAL PRIORITY:	☐ within 1-2 days	☐ within 5 days	☐ more than 5 days	☐ Clinic Round*

Remember MPaCCS IS NOT AN EMERGENCY SERVICE

Date client will be discharged from hospital:

Date of referral: _____

Referring hospital/facility: _____

Ward/unit: _____

Referred by: _____

Position: _____

Other palliative care service involved? *(please name):*

Client aware of referral? ☐ Yes ☐ No

Family aware of referral? ☐ Yes ☐ No

Client aware of diagnosis & prognosis? ☐ Yes ☐ No

If No, why not? _____

GP aware of referral ? ☐ Yes ☐ No

GP name: _____

GP phone: _____ Fax: _____

GP RETAINS CLINICAL RESPONSIBILITY FOR PATIENT

PLEASE INCLUDE: ☐ current medication chart, ☐ most recent hospital discharge summary, ☐ advance care plan

Does the person have a progressive life-limiting condition (malignant or non-malignant)?

Primary Diagnosis: _____

Does the person have symptoms that require specialist assessment/management?

Details: _____

Does your facility need support or education to manage optimally?

Details: _____

Does the person/family have psychosocial or spiritual needs that require specialist assessment?

Details: _____

Does your facility need support with advance care planning for this resident?

Details: _____

Have you discussed the patient's treatment wishes?

(ie resident and family/carer understanding of palliative care, including NFR, antibiotics, transfusions, radiotherapy etc)

Details: _____

Is the resident in the terminal phase (hours/days until death)? ☐ Yes ☐ No

If YES please call 08 9217 1777 to discuss this referral with an MPaCCS nurse or social worker.

Interpreter required? ☐ Yes ☐No Language: _____

Who is the resident's health/medical decision maker? ☐ patient ☐ Public Advocate ☐ other:

Add your email address for MPaCCS to confirm we received your referral:

- *MPaCCS assists facilities & GPs with specialist medical & psychosocial assessment, care planning & case review.*
- *Referrals are accepted from any medical and nursing staff at metropolitan hospitals, mental health & disability services, Department of Corrective Services & residential aged care facilities.*
- *The Supportive & Palliative Care Indicators Tool at www.spict.org.uk can help you identify residents who may need or benefit from a palliative care referral.*

An MPaCCS clinical team member will call you to triage your referral depending on urgency.

Residents receiving life-prolonging treatment are not excluded from referral to palliative care.

*** MPaCCS Clinic Rounds must be arranged in advance with the MPaCCS CNM or CNS – please call our office to discuss.**

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Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2017