Complete this form, save it to your computer, & email it to palliativenurse@bethesda.org.au.

Palliative Care Unit, Bethesda Hospital
25 Queenslea Drive, Claremont
REFERRAL FORM

The PCU accepts referrals 24/7/365.
Email: palliativenurse@bethesda.org.au
Phone: 9340 6311/0449 901 596
Fax: 9340 6491
www.bethesda.org.au/PalliativeCareInternal.aspx

Patient's Full Name			
Patient's Date of Birth		Gender	❒ M ❒ F
Patient's Usual Address			
Patient's Phone #			

Please call the Bethesda Palliative Care Unit to discuss any potential referral about which you are uncertain.

Referral Priority	◯ today (please call)	◯ within 1 – 2 days	◯ within 5 days	◯ more than 5 days
Alerts	❒ infection precautions	❒ wandering patient	❒ physical agression	❒ bariatric patient
ATTACH if AVAILABLE	❒ medication chart/list	❒ hospital discharge summary	❒ current advance care plan/s	

Referrer Name & Mobile		Referral Date & Time	
Referrer Position		GP Name & Mobile	
Current Patient Location		Date Ready for Care	

What is patient's the primary diagnosis? How advanced is the illness? What is the rate of change?					
What other relevant comorbidities trouble the patient?					
Which symptoms trouble the patient (use '++' for most severe)?	❒ insomnia	❒ appetite	❒ nausea	❒ bowels	❒ breathing
	❒ fatigue	❒ pain	❒ delirium	❒ other:	
Does the patient (&/or their family) have unmet psychological, social or spiritual needs?					
What does the patient & their family understand about the patient's current situation & prognosis?					
Is there an advance care plan and/or *Goals of Patient Care* order in place?					

What is the patient's Karnofsky score? (See over for AKPS scoring information.)		Is the patient in the terminal phase? (Terminal phase = days or hours to live.)	❒ Yes ❒ No
What is the patient's main languague?		Is the patient/family aware of this referral?	❒ Yes ❒ No

Please ensure your phone number is correct: a Bethesda PCU clinical team member can call you promptly to triage this referral.

- Bethesda PCU accepts referrals for individuals with cancer & non-cancer life-limiting conditions requiring specialist inpatient management for:
  - assessment, planning & discharge to the community
  - family-carer support
  - symptom management
  - terminal phase care
  - carer respite.
- Referrals are accepted from GPs, residential aged care facilities, community health services, hospitals & disability care providers.
- Individuals receiving life-prolonging treatment are not excluded from palliative care referral.
- Bethesda PCU is managed by Bethesda Healthcare & funded by the North Metro Health Service, WA Department of Health.
- Bethesda PCU accepts public & private patients.

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MR 6.1.5

AKPS: Australia-modified Karnofsky Performance Status			
100	Normal; no complaints; no evidence of disease	40	In bed more than 50% of time
90	Able to carry on normal activity; minor signs or symptoms	30	Almost completely bedfast
80	Normal activity with effort; some signs of symptoms of disease	20	Totally bedfast & requiring extensive nursing care by professionals &/or family
70	Cares for self, but unable to carry on normal activity or to do active work	10	Comatose or barely rousable
60	Requires occasional assistance, but can care for most needs	0	Dead
50	Requires considerable assistance & frequent medical/nursing care	*Consider 'terminal phase' if AKPS is ≤ 20/100, & there has been recent significant functional decline.*	

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

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.
- Progressive weight loss; remains underweight; low muscle mass.
- 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/ vasoular 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 2019