



Specialist Palliative Care Service Referral Form

NB – If referral is urgent a phone call is required

Referral criteria for eligibility:		See WA Health Department Referral to Specialist Palliative Care (click to link)	
Referral date:	/ /	Date referral acknowledged (office use only):	/ /
Date ready for care:	/ /	Referral made to (name of service):	
Referral source			
Name of referrer:		Provider No:	Phone No:
Position/Organisation:		Ward/Unit (if relevant):	
General Practitioner:		GP Phone No:	GP Fax No:
Patient details			
Last name:		First/middle names:	
Date of birth:	/ /	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Indeterminate
Address:			Post code:
Home phone:	Mobile:	Lives alone: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare no:	Medicare expiry date: / /	DVA no:	
Country of birth:		Australian resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred language:	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Communication issues: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indigenous status: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither			
Insurance status: <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Health Fund:			
Patient location: eg. Hospital, Home, RACF		Other services involved: eg HACC	
Has patient been hospitalised outside WA in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last hospital admission: / /	
Diagnosis details (please ensure relevant detailed medical letters and results accompany this form and indicate any attachments below)			
Primary diagnosis:		Date of diagnosis: / /	
Reason for referral:	<input type="checkbox"/> Assessment	<input type="checkbox"/> Direct patient care	
	<input type="checkbox"/> Advice	<input type="checkbox"/> Assistance with discharge planning	
Attachments provided:	<input type="checkbox"/> Consultation	<input type="checkbox"/> Terminal phase	
	<input type="checkbox"/> Support		
	<input type="checkbox"/> Safety alerts	<input type="checkbox"/> Current medications list	
	<input type="checkbox"/> Micro alerts	<input type="checkbox"/> Medical correspondence	
Current issues/needs:	<input type="checkbox"/> Pathology results	<input type="checkbox"/> Diagnostic imaging results	
	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Other	
	<input type="checkbox"/> Physical symptoms	<input type="checkbox"/> Devices	
	<input type="checkbox"/> Psychosocial	<input type="checkbox"/> Wound care	
	<input type="checkbox"/> Equipment	<input type="checkbox"/> Oxygen	
	<input type="checkbox"/> Mobility	<input type="checkbox"/> Other	
Consent			
Is patient aware of diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient consented to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the carer/family aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the GP aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have an Advance Health Directive?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Does the patient have an Enduring Guardian?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Alternative contact/Person responsible/Parent			
Name:		Relationship to patient:	
Address:			Post code:
Home phone:		Mobile:	