Supportive and Palliative Care Specialist Medical Referral Form (Dr Rachel Hughes)

For ambulatory outpatient consultation and Inpatient Consultation St Vincent’s Hospital

**Referrer’s Details:**

|  |  |
| --- | --- |
| Name: |  |
| Contact details: |  |
| Provider number: |  |
| Patients usual GP  ( if not the referring provider): |  |
| Date of referral: |  |

**Patient details:**

|  |  |
| --- | --- |
| Name: |  |
| DOB: |  |
| Address: |  |
| Phone number: |  |
| Gender: |  |
| Marital status: |  |
| Does this patient live alone? |  |

**Key Contact:**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone number: |  |
| Relationship to patient: |  |
| Is the key contact the preferred first point of contact? |  |

|  |  |
| --- | --- |
| Has the patient and key contact been informed and agree to the referral? |  |
| Is the patient known to community palliative care services? |  |

**Clinical information:**

|  |  |  |
| --- | --- | --- |
| Primary Diagnosis for supportive / palliative care consultation: | | |
| Diagnosis | Date | Key Treatment |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Reason for referral (tick all that apply) | |
| ☐ | Pain management |
| ☐ | Medication support and management |
| ☐ | Carer support |
| ☐ | Care navigation / decision making support |
| ☐ | Complex symptom management |
| ☐ | Advance Care Planning / end of life decision making support |
| ☐ | End of life care |
| ☐ | Admission for inpatient management – Reason – respite, symptom control, end of life care |

|  |
| --- |
| Current Palliative Care Problems: |
| 1. |
| 2. |
| 3. |

Current medications (Please provide medication list)

Known adverse drug reactions / allergies:

Does the patient have an advance care plan?

Who is the person responsible if required? Contact details