

Confidential Referral Cover Sheet

Please acknowledge that you have received this referral by completing and signing below and returning via fax/email/mail

Date Sent: dd/mm/yyyy / /

Number of Pages (including cover sheet):

Consumer

Name: _____

Date of Birth: dd/mm/yyyy / /

Sex: _____

UR Number: _____

or affix label here

Referral to

Name: _____

Position: INTAKE WORKER

Organisation: BANKSIA PALLIATIVE CARE SERVICE INC

Phone: 03-94569744

Fax: 03-94553599

Email address: banksia@banksiapalliative.com.au

Address: 472 Lower Heidelberg Rd.
Heidelberg 3084

Agency/Service Provider sending referral

Name: _____

Position: _____

Organisation: _____

Phone: _____

Fax: _____

Email address: _____

Address: _____

Priority

This referral is:

Low *hold over during peak demand*

Routine *attend in date order (this may include the consumer being placed on a waiting list)*

Urgent *cannot wait*

Renewal (ACAS) *For ACAS Assessment*

List of Attachments: (please tick relevant box(es))

<input type="checkbox"/> Consumer Information (required)	<input type="checkbox"/> Summary and Referral (required)	<input type="checkbox"/> Consumer Consent
<input type="checkbox"/> Service Coordination Plan	<input type="checkbox"/> Living Arrangements Profile	<input type="checkbox"/> Functional Profile
<input type="checkbox"/> Health Conditions Profile	<input type="checkbox"/> Psychosocial Profile	<input type="checkbox"/> Health Behaviours Profile
<input type="checkbox"/> Functional Assessment Summary	<input type="checkbox"/> Other: _____	

Other notes:

Referral Acknowledgement

Please be advised that the above referral has been received and: (Please tick appropriate box)

The referral is accepted. Estimated date of consumer assessment dd/mm/yyyy / /

or

The referral is not proceeding for the following reason(s):

<input type="checkbox"/> Consumer declining	<input type="checkbox"/> Waiting list time inappropriate for consumer	<input type="checkbox"/> Ineligible for services	<input type="checkbox"/> Inappropriate referral	<input type="checkbox"/> Other
---------------------------------------------	-----------------------------------------------------------------------	--------------------------------------------------	-------------------------------------------------	--------------------------------

If referral not proceeding provide additional comments below.

Comments and any further actions undertaken:

Date Acknowledged: dd/mm/yyyy / / Name: _____ Position: _____

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer
Name: _____
Date of Birth: dd/mm/yyyy / /
Sex: _____
UR Number: _____
or affix label here

Consumer details

Family Name: _____

Given Names: _____

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? _____ Code:

Preferred Name/s: _____

Sex: _____ Code: Title: _____

Contact Address (for correspondence, home visits etc.)

Usual Address (if different from contact address)

Contact phone number/s (check preferred number) Can leave message?

Home: () Yes No

Work: () Yes No

Mobile: Yes No

Email: Yes No

Country of Birth: _____ Code:

Indigenous Status: _____ Code:

Need for Interpreter Services: _____ Code:

Preferred Language: _____ Code:

Communication Method: _____ Code:

General Practitioner (if no GP, write NA)

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name: _____

Contact Address

Phone numbers

Home: _____

Work: _____

Mobile: _____

Relationship to Consumer: _____ Code:

Is this person the consumer's carer? _____ Code:

Person 2 Name: _____

Address: _____

Phone: _____

Government Pension/Benefit Status: _____ Code:

Health Care Card Holder Status: _____ Code:

Card number: _____

Medicare Card:

Card number: _____

Health Insurance Status:

Insurer name: _____

Card number: _____

DVA Card Entitlement:

DVA card type: _____ Code:

DVA card number: _____

Compensables Funding Source: _____ Code:

Comments:

Consumer Information

This information collected by:

Name: _____ Position/Agency: _____

Sign: _____ Date: dd/mm/yyyy / / Contact number: _____

Palliative Care Clinical Referral

This supplementary form should accompany the SCTT 2006 Cover Sheet, Consumer Information, and Summary & Referral forms for referrals to palliative care services. Page 2 of 3.

Consumer Family Name: Given Names: Date of Birth: Sex: UR Number:

Treatment

Key Symptom Issues: <input type="checkbox"/> Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Breathlessness <input type="checkbox"/> Anxiety <input type="checkbox"/> Fatigue Other:
Current Treatment (including chemotherapy regimens / radiotherapy plans if applicable - see Summary & Referral form for medications):
Advance Care Plans (client understanding of pall. care, and discussions re NFR, antibiotics, transfusions, radiotherapy):

Nursing Care

Personal Care: Does the client have difficulty or need assistance with dressing or grooming, bathing or showering, or other personal care?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Continence: Does the client require continence management, e.g. IDS, pads?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Mobility: Does the client have difficulty or need assistance with mobility, e.g. walking or moving around the house? Do they need or have any aids, e.g. a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Falls Risk:	
Nursing Issues (e.g. peg feed, nasogastric tube in situ, tracheostomy, home oxygen): 	

Produced by the North and West Metropolitan Region Palliative Care Consortium, 2007

This form completed by:

PCCR (version 2007.1) Page 2 of 3

Name:

Position / Agency:

Date:

Contact number:

Palliative Care Clinical Referral

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Consumer Family Name: Given Names: Date of Birth: Sex: UR Number:

Living Arrangements and Psychosocial Issues

Living Arrangements: <input type="checkbox"/> 1 Lives alone <input type="checkbox"/> 2 Lives with carer <input type="checkbox"/> 3 Lives in supported accommodation	
Social Support (<i>comment on personal and social support, including social isolation and family and personal relationships</i>): 	
Is the client aware of the diagnosis and prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? Is the family aware of the diagnosis and prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? Has a family meeting been held? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Inpatient setting <input type="checkbox"/> Community setting Date:	
Psychosocial Issues (<i>e.g. family & personal relationships, previous losses, family problems, concurrent life crises</i>): 	
Cultural considerations: 	
Challenging Behaviours: Does the person have behavioural problems, for example aggression, wandering or agitation?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Cognition: Does the person have memory problems or get confused?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Religion: Parish:	Spiritual screening attended? <input type="checkbox"/> Yes <input type="checkbox"/> No Pastoral care contact:

Multidisciplinary Assessments

Have any relevant assessments been carried out (e.g. Aged Care, Physiotherapy, OT, Social Work, Volunteer or other)?
 Please list type of assessment, and contact details of assessing practitioner. Please include or attach assessment summaries.

Assessment	Assessor Name and Phone Number	Notes
Aged Care		

Other Information

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Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Family Name:

Given Names:

Date of Birth:

Sex:

UR Number:

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of Issues *(see Palliative Care Clinical Referral form for further details)*

Current presentation/episode, presenting problem(s) *(observed or described features; screening evidence):*

Significant Histories, Recent and past history *(medical, functional/daily living skills, social, emotional etc.):*

Medications *(list medications at time of referral, do not include dosages):*

Other:

Alerts

Allergies:

Risks: None identified Consumer at risk Care worker at risk Others at risk

Details:

Additional comments including urgency:

Produced by the Victorian Department of Human Services, 2006

This form completed by:

SRI Page 1 of 2

Name:

Position / Agency:

Date:

Contact number:

