Illawarra Shoalhaven Local Health District

Facility:

REFERRAL TO ISLHD SPECIALIST COMMUNITY PALLIATIVE CARE SERVICE

FAMILY NAME:	MRN:
GIVEN NAME:	☐ MALE ☐ FEMALE
D.O.B ___ / ___ / _____	M.O.
Address	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**Please consider if this referral is for non-palliative pain management or early dementia management it may be more appropriate to refer to services such as Pain Clinic, Geriatrician or ACAT.*

PATHOLOGY & IMAGING: Please attach all relevant information

Client Details	
Name	
Preferred Name	
Date Of Birth	
Address	
Home Phone	
Mobile	
Email	
Gender	☐ Male ☐ Female ☐ Unknown ☐ Other_____
Country of Birth	
Preferred Language	
Interpreter Needed?	☐ Yes ☐ No

Aboriginality

- ☐ Aboriginal, not Torres Strait Islander Origin
- ☐ Torres Strait Islander, not Aboriginal Origin
- ☐ Aboriginal and Torres Strait Islander Origin
- ☐ Neither Aboriginal or Torres Strait Islander Origin
- ☐ Not stated / inadequately described

Does the person have a carer?

- ☐ Yes
- ☐ No

Does the person live alone?

- ☐ Yes
- ☐ No

Client Consent

Does the client or Person Responsible understand the palliative approach and have they agreed to this referral?

☐ **Yes** ☐ **No**

Referrer Details	
Name	
Practice	
Provider No.	
Address	
Phone	
Fax	
Email	

GP Details	
Name	
Practice	
Phone	

Client's Person to Contact Information	
Name	
Phone	
Relationship	
Consent to Contact	Yes ☐ No ☐

Medical and Social History

Medications	Yes ☐ No ☐ **Refer to attached documents*
Allergies	
Other Care Providers:	

IS010504

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

IS010504 200922

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IS010.504

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Referral Details

Date of Referral	
Referral Urgency	☐ Urgent / immediate ☐ Days ☐ Weeks
Diagnosis	

Reason for referral

- ☐ complex pain/symptom management end of life care
- ☐ functional decline
- ☐ carer needs in context of a palliative illness
- ☐ other: _____

Not eligible for service if referred for non-palliative pain management

ADDITIONAL COMMENTS, INSTRUCTIONS, ALERTS

Revelant Social Situation and History

- ☐ NDIS
- ☐ Aged Care Package
- ☐ DVA
- ☐ Other _____

Does the client have a current:

- ☐ Advance Care Plan/Directive
- ☐ Enduring Guardian

Other Specialists involved

Specialists Names and details	

PLEASE EMAIL REFERRAL:

ISLHD-AccessandReferralCentre@health.nsw.gov.au

For referrals call 1300 792 755

For Urgent Referrals (ISLHD Community Palliative Care Service) call 1300 068 458 or Fax: 02 4253 0355