

Medications

Known allergies: _____

Current medications:

(please attach copy of current medication chart)

Name	Dose	Frequency

Details of Family/Carer(s)

Name	Relationship	Role NoK/EPOA/Carer	Contact (phone/address) (If different from patient)

Is there an existing Power of Attorney for Health and Welfare? Yes No (If yes please identify above)

Other Services Involved or Referred to

Organisation	Main Contact

Referrer Details

Name: _____ Position: _____
 Organisation: _____ Dept: _____
 Telephone: _____ Mobile: _____
 E-mail: _____ Fax: _____

Further Information

Please also include relevant clinical correspondence (letters, discharge summaries, etc), test results, advance care plan

Hospice Use Only

Referral review meeting notes: _____

Date: _____ Sign: _____

Referral decision: Accept: Decline:

Urgency: Urgent Routine

Team: H@H ROS IPU FS OPC

Care Coordinator: _____

Entered in Palcare

Date: _____

By: _____

Referral source:

- General Practice
- Public Hospital – palliative care
- Public Hospital – Other
- Community Service - District Nurse
- Residential care
- Other

Diagnosis Type:

- Malignant
- Non-Malignant - Dementia
- Non-Malignant - Renal
- Non-Malignant - Other Neurological
- Non-Malignant - Cardiovascular
- Non-Malignant - Respiratory
- Non-Malignant - Multiple organ failure
- Non-Malignant - Hepatic Liver
- Non-Malignant - Other

Fax completed form to: (07) 859 1266