Palliative Care Referral Triage and Transfer Form

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

Does the person identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No AHLO contacted? ☐ Yes ☐ No

Patient living alone: ☐ Yes ☐ No Carer Support ☐ Yes ☐ No Remote Area ☐ Yes ☐ No

General Practitioner: _____ Available for home Visits: ☐ Yes ☐ No ☐ Unsure

Contact phone No: _____ Contact by phone A/h: ☐ Yes ☐ No ☐ Unsure

Main Carer: _____ Relationship: _____ Phone No: _____

Address (if different to patient): _____

Does the patient have *(tick)*	**Who/Where**	**Dated**
☐ Not for Resuscitation Order		
☐ Limitation of Medical Treatment		
☐ Advance Care directive /Goals of care form		
☐ Advance Care Plan		
☐ Medical treatment decision maker		

Estimated prognosis *(tick one)* ☐ Day ☐ Weeks ☐ Months ☐ 6-12 months

Discussion with patient regarding ☐ diagnosis ☐ prognosis ☐ benefit of referral to palliative care

Discussion with family /carer regarding ☐ diagnosis ☐ prognosis ☐ benefit of referral to palliative care

Patient has consent for referral to:

☐ Palliative Care Specialist Outpatient Clinic

☐ Community-based Service

If referred to above options, please email:
district.nursing@basscoasthealth.org.au
If referral is considered urgent please also phone
District Nursing on (03) 5671 9219

☐ Inpatient unit / Hospital admission

☐ Residential Aged Care

Urgency of Referral

☐ 24 Hours; (urgent; patient unstable, rapidly deteriorating or is in the terminal/dying phase)

☐ Two working days; (patient experiencing distress physical and/or psychosocial symptoms not responding to established palliative care management/protocols)

☐ One week; (patient stable but seeking palliative care information and support)

☐ Is an inpatient; (considering transfer to community palliative care)

Main diagnosis, relevant history and management

Please attach copies of recent medical correspondence, recent screening/imaging and blood tests

What is the trigger for palliative care referral?

☐ 1. Symptom assessment and management ☐ 2. Terminal Phase ☐ 3. Respite Care

Details: _____

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MR/316

BCH3516

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ALERTS including known allergies / medication sensitivities / cytotoxic precautions

Current medications, dose route frequency time of last medication review (if known)

Any other relevant information include family issues dynamics, cultural needs and any concern about carer

Home Help Services (tick if in place)

☐ Home Help ☐ Property maintenance ☐ Carer Services ☐ ACAS Assessment ☐ Other: _____

Problem Severity Score Clinician rated 0=Absent, 1=mild, 2=moderate, 3=severe Please apply number to relevant symptoms		Phase of illness-definitions according to Palliative Care outcomes Collaborative (PCOC) Clinician rated (tick one)	Australian modified Karnofsky Performance Scale (AKPS) (tick one)
Difficulty sleeping		☐ Phase 1: Stable Symptoms are adequately controlled by established management	☐ 100 Normal, no complaints or evidence of disease
Appetite problems		☐ Phase 2: Unstable Development of a new problem or a rapid increase in the severity of existing problems	☐ 90 Able to carry on normal activity, minor signs of illness present
Nausea		☐ Phase 3: Deteriorating Gradual worsening of existing symptoms or the development of new but expected problems	☐ 80 Normal activity with effort, some signs or symptoms of disease
Bowel problems		☐ Phase 4: Terminal Death likely in a matter of days	☐ 70 Able to care for self, but unable to work or carry on other normal activities
Breathing problems		☐ Phase 5: Bereaved Death of a patient has occurred and the carers are grieving	☐ 60 Able to care for most needs but requires occasional assistance
Fatigue			☐ 50 Considerable assistance and frequent medical care required
Pain			☐ 40 In bed more than 50% of the time
Psychological/ spiritual			☐ 30 Almost completely bedfast
Family/carer			☐ 20 Totally bedfast & requiring nursing care by professionals and/or family
Other			☐ 10 Comatose, or barely rousable
			☐ 0 Death

Other Comments: _____

Referred by

☐ Nurse ☐ Consultant ☐ Hospital ☐ Community Health Centre ☐ GP ☐ Other: _____

Name: _____ Name of Organisation: _____

Date: ____ /____ /____

Name of Nurse receiving: _____ Signature: _____

Designation: _____ Date: ____ /____ /____

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