MATER HOSPITAL
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

PALLIATIVE CARE REFERRAL

Surname	MRN
Given name	
DOB ...../...../.....	☐ Male ☐ Female
Ward:	
Complete all patient details or affix patient label here	

Date of referral: _____

Name of person making referral: _____ Designation: _____

Provider number*: _____ Signature: _____

***required for medical referrals.* Email completed form to admin.materpalliativecare@svha.org.au**

Reason for referral:

Specialist medical consult for:

Complex pain and symptom management ☐ End of life care ☐ Other ☐ _____

CNC consult for:

Symptom management advice ☐ Link to community palliative care service ☐

Allied Health consult:

Physiotherapist ☐ Occupational Therapist ☐ Social Worker ☐ Pastoral & Spiritual care ☐

Link to community palliative care service ☐ _____

N.B. For home oxygen please refer to resource folder on the ward

Has the patient consented to this referral*? Yes ☐ No ☐

Has the patient consented for their care to be discussed at the Palliative Care MDT Meeting? Yes ☐ No ☐

(please document consent in patient progress notes or person responsible if the patient is unable to consent)

Prognosis (in your opinion): this patient has a prognosis of ☐ Days ☐ Weeks ☐ Months ☐ Years

Does the patient have an enduring guardian? Y ☐ N ☐

Does the patient have an advance care directive? Y ☐ N ☐

Diagnosis/relevant history:

_____

_____

_____

_____

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_____

Issues/Problems to be addressed by referral:

_____

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Triggers for referral

- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- The referring clinician would not be surprised if the patient died within the next 12 months
- Recurrent presentations to hospital with a chronic life-limiting illness
- For inpatients, it would not be a surprise if they died this hospital admission
- Progressive disease despite life-prolonging therapy
- Low probability of success from available therapeutic options (e.g. later line treatment for advanced malignancy)
- Withdrawal, or consideration of withdrawal, of life prolonging treatment (e.g. haemodialysis, ventilation)
- Patient or family concerns about end of life issues
- Recent marked decline in physical function/performance status with limited reversibility
- Care needs exceed carer capacity
- Patient requests palliative care referral

Adapted from WA Cancer and Palliative Care Network (2014), *Referral to Specialist Palliative Care*. https://ww2.health.wa.gov.au/Articles/N_R/Palliative-Care