Palliative care supplementary information

Purpose: to assist workers/practitioners to communicate additional information required for palliative care referrals.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Referral

Referral type

☐ To community based service

☐ To inpatient service, for admission

☐ To inpatient service, for respite

Inpatient details

Name of hospital/facility: _____

Is the consumer an Inpatient? ☐ Yes ☐ No

Ward/Clinic: _____

Reason for admission: _____

Expected discharge date: dd/mm/yyyy / /

Specialist details:

1. Name: _____
   Profession/specialty: _____
   Hospital/clinic Name: _____
   Address: _____
   Phone: _____
   Fax: _____
   Email: _____
   Contact details for medical consultant
   Name: _____
   Phone: _____

2. Name: _____
   Profession/specialty: _____
   Hospital/clinic Name: _____
   Address: _____
   Phone: _____
   Fax: _____
   Email: _____
   Contact details for medical consultant
   Name: _____
   Phone: _____

Additional medical history/treatment

Primary diagnosis *(include histology if applicable):*

_____

Date of primary diagnosis
(dd/mm/yyyy) / /

Secondary diagnosis:

_____

Date of secondary diagnosis
dd/mm/yyyy / /

Additional medical history
(attach relevant imaging, blood test results, medication list etc)

Karnofsky (Australian) performance score:

Date completed (dd/mm/yyyy): / /

☐ 100 Normal; no complaints; no evidence of disease
☐ 90 Able to carry on normal activity; minor signs or symptoms
☐ 80 Normal activity with effort; some signs of symptoms of disease
☐ 70 Cares for self; unable to carry on normal activity or to do active work
☐ 60 Requires occasional assistance but is able to care for most of needs
☐ 50 Requires considerable assistance and frequent medical care
☐ 40 In bed more than 50% of time
☐ 30 Almost completely bedfast
☐ 20 Totally bedfast and requiring extensive nursing care by professionals and/or family
☐ 10 Comatose or barely rousable

Key symptom issues

☐ Pain ☐ Tiredness ☐ Nausea ☐ Depression ☐ Anxiety ☐ Shortness of breath
☐ Drowsiness ☐ Appetite ☐ Wellbeing ☐ Constipation ☐ Diarrhoea ☐ Other: _____

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Additional medical history/treatment (cont.)

Current and planned *treatment* *(including treatment regimens/plans if applicable, information about upcoming appointments and information about how much medication the patient is discharged home with)*

Advance Care Planning

Does the consumer have an Advance Care Plan?	☐ Yes ☐ No ☐ Not stated/unknown If yes, where is it kept?
Does this include a Refusal of Treatment Certificate or other documentation limiting treatment?	☐ Yes ☐ No ☐ Not stated/unknown
Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?	☐ Yes ☐ No ☐ Not stated/unknown If yes, name of substitute decision maker?

Consumer/family awareness of diagnosis and prognosis

Consumer awareness

Diagnosis ☐ Yes ☐ No

Comments:

Prognosis ☐ Yes ☐ No

Comments:

Family/carer awareness

Diagnosis ☐ Yes ☐ No

Comments *(specify individual family member/carer awareness and any related issues)*:

Prognosis ☐ Yes ☐ No

Comments *(specify individual family member/carer awareness and any related issues)*:

Multidisciplinary assessments

Have any relevant assessments been carried out
(eg aged care, physiotherapy, occupational therapy, social work, volunteer or other)?

☐ Yes ☐ No

Assessment	Assessor name	Assessor phone number	Notes
eg aged care			

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Nursing care

(*eg peg feed, nasogastric tube in situ, tracheostomy, home oxygen*):

Psychological and spiritual issues

Psychological/current family/carer issues
(*eg family and personal relationships, previous losses, family problems, concurrent life crises*):

Cultural, religious and spiritual considerations

Other

Include/attach any other relevant information

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