Palliative Care Supplementary Information

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	**Inpatient details**
☐ 1. To Community based service ☐ 2. To inpatient service, for admission ☐ 3. To inpatient service, for respite	Name of hospital/facility: Is the Client an Inpatient? ☐ Yes ☐ No Ward/Clinic: Reason for Admission: Expected discharge date:

Specialist details

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

Additional medical history/treatment

Primary Diagnosis (*include histology if applicable*):	**Secondary Diagnosis**:
Date of Primary Diagnosis dd/mm/yyyy / /	**Date of Secondary Diagnosis** dd/mm/yyyy / /

Additional medical history
(refer to SCTT health conditions for recording medications) (attach relevant imaging, blood test results etc)

Karnofsky 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 being discharged home with)

Advance care planning
(client and family/carer understanding of palliative care, and discussions about topics including Not For Resuscitation (NFR), antibiotics, transfusions, radiotherapy. This may take a range of forms including):

Advance Care Plan Completed? ☐ Yes ☐ No

Medical Power of Attorney Attached ☐ Yes ☐ No

Not For Treatment order (eg refusal of treatment certificate) completed ☐ Yes ☐ No

Client/family awareness of diagnosis and prognosis

Client 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
(e.g. aged care, physiotherapy, occupational therapy, social work, volunteer or other)?

☐ Yes ☐ No

Assessment	Assessor Name	Assessor Phone Number	Notes
e.g. Aged Care			

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Nursing care

(*e.g. peg feed, nasogastric tube in situ, tracheostomy, home oxygen*):

Psychological and spiritual issues

Psychological/Current family/carer issues
(*e.g. family & 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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