



Community Palliative care REFERRAL FORM

Referral date:

Referrer's name:

Organisation:

Referrer's Contact No:

☐ Acute ☐ Sub-Acute ☐ Community

☐ Medical ☐ Nursing ☐ Allied Health ☐ Social Work

Has the patient consented to this referral? Yes ☐

Attach Bradma label here, or complete details.

Hospital UR#:

Surname: Given Name:

Address:

Suburb: Post Code:

DOB: Ph: ☐ Male ☐ Female

Medicare number:

Marital status:

Country of birth:

Aboriginal /Torres Strait Islander ☐ Yes ☐ No

General Practitioner.....

For community patients: Has the GP agreed to the referral ☐ Yes ☐ No



Please fax referral to Att: Community Palliative Care - Fax: 03 5521 0372

Level of Urgency	
Within 24 hours → <input type="checkbox"/> Terminal Care <input type="checkbox"/> Deteriorating <input type="checkbox"/> Complex/ Poorly Controlled Symptoms	Non Urgent → <input type="checkbox"/> Case Conference <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Symptom Assessment <input type="checkbox"/> Other
<input type="checkbox"/> Malignant <input type="checkbox"/> Non Malignant	
What is your primary concern for this assessment?	
.....	
.....	

Have you attached current list of medications? Yes ☐

Does the patient have an Advance Care Directive? Yes ☐ No ☐

Diagnosis:

Current Symptoms/Treatment:

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Patient's Usual Arrangements	Carer Availability
<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with others <input type="checkbox"/> Not stated	<input type="checkbox"/> Has a carer; Name:
<input type="checkbox"/> Home <input type="checkbox"/> Residential Care <input type="checkbox"/> SRS <input type="checkbox"/> Other	<input type="checkbox"/> Co-Resident <input type="checkbox"/> Non resident <input type="checkbox"/> Has no Carer

Supportive and Palliative Care Indicators Tool (SPICTM)

The SPICTM is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.