HammondCare
An independent Christian charity

Specialist Palliative and Supportive Care referral form

PATIENT NAME		
ADDRESS: TEL NO:		
DOB	SEX	MRN

Referral to : ☐ **PALLIATIVE CARE INPATIENT UNIT** ☐ **COMMUNITY PALLIATIVE CARE SERVICE**

ATTENTION: ☐ **Dr Melanie Lovell (Greenwich)** ☐ **Dr Sarah Thompson (Neringah)**
☐ **Dr Geraldine Lake (Northern Beaches)**

Date: _____

Referred by: _____

Referrer's phone no.: _____

On behalf of Dr _____

Hospital: _____

GP aware of referral? ☐ yes ☐ no

Patient location: _____

Consent to referral? ☐ patient ☐ family

Person responsible: _____

Relationship: _____ Phone no.: _____

Name of palliative care consultant: _____

GP: _____

Practice name: _____

Phone no: _____

Medicare no.: _____

Health fund name: _____ No.: _____

Language: _____ Lives alone? ☐ yes ☐ no

Interpreter needed? ☐ yes ☐ no

Reason for referral (can select more than one):
☐ symptom control ☐ terminal care ☐ psychosocial support ☐ supportive care

Diagnosis and treatment:

Medical history:

Please attach relevant documents not available on eMR (eg. scanned results, consult sheets, correspondence) ☐

NSW Health Resuscitation Plan completed? yes ☐ (Please attach) no ☐

Infection status and location:

Special instructions (tracheostomy, wound care, CVADs, PEG, modified diet needs):

Falls risk / behavioural concerns:

Functional status: ☐ independent ☐ partial assist ☐ full assist Aids: _____

Skin integrity: Waterlow score: _____

Patient and family concerns: _____

Understanding of disease: _____

Goals of care: _____

Spiritual / cultural needs: _____

Referring GP/specialist signature:

Provider no.:

Date:

PLEASE FAX COMPLETED REFERRAL TO:

Greenwich Hospital	Inpatient Unit	F: 9903 8100	Ph: 9903 8227
	Community	F: 9903 8265	Ph: 8437 7330
Neringah Hospital	Inpatient Unit	F: 9487 1599	Ph: 9488 2200
	Community	F: 9488 2247	Ph: 9488 2290
Northern Beaches	Community	F: 9979 7221	Ph: 9998 3600

(For urgent referrals please phone the relevant number above)