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|  | **SPECIALIST PALLIATIVE CARE REFERRAL FORM**  Please forward completed form to your local service provider.  Contact details available at:  <http://www.iapc.ie/directory> and<http://www.icgp.ie/palliative> |

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| **Patient Details** | | | |
| **Name:**  **Address:** | **Date of Birth:**  **Phone:**  **Mobile:** | | **Gender:**  **Medical Card:**  **Health Ins:** |
| **Current Location:** | | **Is the Patient Living Alone?** | |

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| **Contact Person** | |
| **Contact Person (Family/Friend):**  **Relationship:** | **Address:**    **Phone:** |

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| **Referral For:**  Hospice Admission:  Community Based Services\*:  Hospital OPD:  Other:  \*Subject to availability, services may include OPD, Day Hospital, Community Specialist Palliative Care Team (Home Care Team) or other. | | **Urgency of Referral:**  (Subject to Triage by Specialist Palliative Care Team)  Two working days\*  \*Must be accompanied by phone contact from Referrer  One Week  Two Weeks  Pending | | |
| **Diagnosis, treatment to date, further treatment planned (e.g. recent admission(s), radiotherapy, chemotherapy, etc.)**  **PLEASE ATTACH COPIES OF RECENT CORRESPONDENCE, IMAGING REPORTS AND BLOOD RESULTS** | | | | |
| **Active Problem(s)/Reason(s) for Referral:** | | | | |
| **Other Medical Conditions +/- Infection Control Issues (e.g. MRSA):** | | | | |
| **Patient’s Name:**       **Date of Birth:** | | | | |
| **Current Medication - Dosage and Significant Recent Changes:** | | | | |
| **Known Allergies/Drug Side-Effects:** | | | | |
| **Performance Status:**  (Please tick which applies)   1. Ambulatory and able to carry out light work 2. Ambulatory, capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours 3. Capable of only limited self-care, confined to bed or chair more than 50% of waking hours 4. Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair | | | | |
| **Estimation of Prognosis:**: **Days**  **Weeks**  **Months**  (Please tick one)  **Awareness of diagnosis/prognosis/referral to palliative care:**  **Patient Family and/or Carer**  **Diagnosis**:  **Prognosis**:  **Referral**: | | | | |
| **Any other relevant information** (include other contact details, family issues, other health care professionals involved, interpreter required etc): | | | | |
| **PLEASE COMPLETE IN BLOCK CAPITALS** | | | | |
| **GP:**        **GP Phone:**        **GP Address:**        **GP Aware of Referral**: | **Consultant(s):** | | **Referred By:**  **Job Title:**  **Place of Work:**  **Phone:** | |
| **Date:**  **Signature:** | | | |