Please see reverse side for referral criteria

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| **Patient Details** | |
| Name | |
| Date of Birth | Ethnicity Contact No. |
| NHI | Gender |
| Address | |
| First Contact name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ number:­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  € Patient and/or family are aware and have consented to this referral  € GP is aware of this referral  € Urgent referral please phone 5664535 | |
| **GP Details (this section must be completed before the referral will be accepted)** | |
| GP Name | |
| Practice Address | |
| Contact Number Email: | |
| Primary diagnosis | |
| Reason for referral | |
| Relevant other co-morbidities | |
| Brief history and examination | |
| **PLEASE INCLUDE ALL COPIES OF RELEVANT CLINIC LETTERS AND INVESTIGATIONS** | |
| Name of Referrer: Signature: Date: | |
| Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**PTO for referral criteria**

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| **Referral Criteria**  **Patients with a life limiting illness who have:**   * Active/Progressive/Advanced disease where the focus is now quality of life * Psychological distress related to palliative care * Physical uncontrolled symptoms related to palliative care * Complex end of life care |

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| **Who will we accept referrals from?**   * GP/practice nurse * CNS * Hospital teams * Aged Care * Patients and family (needs to be in consultation with GP, GP will remain involved with care) * Community agencies eg mental health * Other hospices/palliative care services |

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| **Urgent referrals will be contacted within 24 hours; all other within 72 hours** |

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| **What happens when we decline a referral:**   * You will be advised about the appropriate services * Indicate reasons and provide a documented response |

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| **PLEASE NOTE:**  **Include on referral: Contact number and email address must be included on referral. All relevant test results and letters need to be attached.** |