



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NATIONAL SPECIALIST PALLIATIVE CARE REFERRAL FORM

Please forward the completed form to your local service provider.

Local Services may be identified using the [HSE Area Finder](#)

Click [Online Referral Form](#) for further copies

Click here for the [Eligibility Criteria for SPC Services - access and discharge](#)

Click here for the [Palliative Care Needs Assessment Guidance](#)

Patient Details

Name: Address: Eircode:	Date of Birth: Contact Tel Nos.: PPS No.:	Sex at Birth: Preferred Language: Translator Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Medical Card: Yes <input type="checkbox"/> No <input type="checkbox"/> Medical Card No. (If applicable):
Current Location:	Patient Lives Alone?: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Main Contact Person – Family/Carer/Representative		
Contact Name: Relationship: Eircode:	Phone No.: Address:	
First Contact in an emergency (if not the above): Relationship:		Phone No.:
Referral for which Specialist Palliative Care Service: <input type="checkbox"/> Admission to Hospice/Inpatient Unit* <input type="checkbox"/> Community Based Services*/** <input type="checkbox"/> Hospital Inpatient Review <input type="checkbox"/> Hospital Outpatient Review <input type="checkbox"/> Other(Specify): *Subject to triage & availability. **May also include OPD, SPC Day Unit, or other.	Urgency of Referral: (Subject to Triage by Specialist Palliative Care Team) <input type="checkbox"/> Within Two working days* *Referral must be accompanied by phone call from referrer <input type="checkbox"/> Within One Week <input type="checkbox"/> Within Two Weeks <input type="checkbox"/> For Information Only	
Diagnosis, (cancer or non-cancer) previous and current treatments, recent hospital admissions & future treatment plans Please attach relevant correspondence, bloods, and imaging results. Incomplete information may delay triage and first assessment Future Care Plan/Treatment Escalation Plan in place Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, please describe: Advance Healthcare Directive in Place: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> DNACPR decision in Place: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		
Active or anticipated problem(s)/reason(s) for referral: Consider Physical, Psychological, Spiritual, Social, Family/Carer domains		
Other Medical Conditions +/- Infection Control issues (e.g., MRSA, VRE, CPE, KPC, others):		

Patient's Name:		Date of Birth:		PPS No.:	
Current Medications – doses and significant recent changes:					
Known drug allergies/ Side-effects/Sensitivities to medications/dressings etc.:					
Equipment/devices currently in use					
Long Term O₂ Therapy: Yes <input type="checkbox"/> No <input type="checkbox"/> Non-Invasive Ventilation: (Please specify type): Tracheostomy: Yes <input type="checkbox"/> No <input type="checkbox"/>			Active Implantable Cardioverter Defibrillator (ICD): Yes <input type="checkbox"/> No <input type="checkbox"/> IV Access/Port (Please specify type): Clinical Equipment (Please specify type): Miscellaneous Equipment (Please specify type):		
Australian-Modified Karnofsky Performance Status (AKPS): <div> <input type="checkbox"/> 100. Normal, no complaints or evidence of disease <input type="checkbox"/> 50. Requires considerable assistance and frequent medical care </div> <div> <input type="checkbox"/> 90. Able to carry on normal activity, minor signs or symptoms of disease <input type="checkbox"/> 40. In bed more than 50% of the time </div> <div> <input type="checkbox"/> 80. Normal activity with effort, some signs or symptoms of disease <input type="checkbox"/> 30. Almost completely bedfast </div> <div> <input type="checkbox"/> 70. Care for self, unable to carry on normal activity or to do active work <input type="checkbox"/> 20. Totally bedfast & requiring nursing care by professionals and/or family </div> <div> <input type="checkbox"/> 60. Occasional assistance but is able to care for most needs <input type="checkbox"/> 10. Comatose or barely rousable </div>					
Estimation of Prognosis: Awareness of diagnosis, prognosis, and referral to specialist palliative care					
Estimation of Prognosis: (Please tick one) Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/>					
Patient aware?: Diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Prognosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Referral: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>			Are Family and/or Carer aware?: Diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Prognosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Referral: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>		
Any other relevant information: (e.g., other contact details, family or other domestic issues of concern, other health care professionals involved, etc.)					
Details of GP and Consultants involved in the patient's care.					
GP's Name: GP's Phone No.: GP's Address: GP Aware of Referral: Yes <input type="checkbox"/> No <input type="checkbox"/> Is the GP content to complete a death notification form in the event of an anticipated death?: Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>			Consultant's Name(s): Hospital Location(s): 		
Referred by: Name: Job Title: Place of Work: Contact Tel No/Bleep:			Referrer's Signature: Referrer's Registration No: Date:		