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|  | **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](https://hseareafinder.ie/)  Click [Online Referral Form](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/referring/) for further copies  Click here for the [Eligibility Criteria for SPC Services - access and discharge](https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/eligibility-criteria-for-access-to-discharge-from-specialist-palliative-care-services.pdf)  Click here for the [Palliative Care Needs Assessment Guidance](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/needs-assessment-guidance/palliative-care-needs-assessment-guidance-2411.pdf) |

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| **Patient Details** | | | |  |  |
| **Name:**       **Address:** | **Date of Birth:** Enter a date     **Contact Tel Nos.:**  **PPSN No.:** | | **Sex at Birth:** Select  **Preferred Language:**        **Translator Required:** Select  **Medical Card:** Select | | |
| **Eircode:** |  | | **Medical Card No.** (If applicable): | | |
| **Current Location:** | **Patient Lives Alone?:**Select | | | |  |
| **Main Contact Person – Family/Carer/Representative** | | | | | |
| **Contact Name:**        **Relationship:**        **Eircode:** | | **Phone No.:**        **Address:** | | | |
| **First Contact in an emergency (if not the above):**       **Phone No.:**  **Relationship:** | | | | | |
| **Referral for which Specialist Palliative Care Service:**  Admission to Hospice/Inpatient Unit\*  Community Based Services\*/\*\*   Hospital Inpatient Review  Hospital Outpatient Review  Other: | **Urgency of Referral:**  (Subject to Triage by Specialist Palliative Care Team)  Within Two working days\*  \*Referral must be accompanied by phone call from referrer  Within One Week  Within Two Weeks  For Information Only | | | | |
| \*Subject to triage & availability. \*\*May also include OPD, SPC Day Unit, or other. |  | | | | |
| **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** Select **If yes, please describe:** | | | | | |
| **Advance Healthcare Directive in Place**: Select **DNACPR decision in Place**: Select | | | | | |
| **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): | | | | | |

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| **Patient’s Name:**       **Date of Birth:** Enter a date **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**: Select **Non-Invasive Ventilation**: Select **Tracheostomy**:Select | **Active Implantable Cardioverter Defibrillator (ICD)**: Select **IV Access/Port** (If other please specify): Select Other:       **Clinical Equipment** (If other please specify): Select Other:       **Miscellaneous Equipment** (If other please specify): Select Other:  Clinical Equipment (If other please specify):  (if other please specify) Choose an item. | | |
| **Australian-Modified Karnofsky Performance Status (AKPS)**:Select   |  |  |  |  | | --- | --- | --- | --- | | 100. | Normal, no complaints or evidence of disease | 50. | Requires considerable assistance and frequent medical care | | 90. | Able to carry on normal activity, minor signs or symptoms of disease | 40. | In bed more that 50% of the time | | 80. | Normal activity with effort, some signs or symptoms of disease | 30. | Almost completely bedfast | | 70. | Care for self, unable to carry on normal activity or to do active work | 20. | Totally bedfast & requiring nursing care by professionals and/or family | | 60. | Occasional assistance but is able to care for most needs | 10. | Comatose or barely rousable | | | | |
| **Estimation of Prognosis: Awareness of diagnosis, prognosis, and referral to specialist palliative care** | | | |
| **Estimation of Prognosis:** (Please tick one) **Days**  **Weeks**  **Months**  **Years** | | | |
| **Patient aware?:**  **Diagnosis**: Select **Prognosis**: Select **Referral**: Select | | **Are Family and/or Carer aware?:**  **Diagnosis**:Select **Prognosis**: Select  **Referral**: Select | |
| **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:**        **GP’s Address:**        **GP Aware of Referral**: Select  **Is the GP content to complete a death notification form in the event of an anticipated death?:**  Select  Click or tap here to Enter text. | | | **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:** Enter a date. |

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