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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 ReferrerOne 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[ ]
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| **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:**  |