|  |  |
| --- | --- |
|  | **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 copiesClick 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) |

|  |  |  |
| --- | --- | --- |
| **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):       |

 NCPPC Version 3 2024

|  |
| --- |
| **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. |

 NCPPC Version 3 2024