Feidhmeannacht na Seirbhise Sainte
Health Service Executive

Specialist Palliative Care Service Referral Form

Please forward completed form to your local service provider
Contact details available at: www.icgp.ie/palliative
http://www.iapc.idiape-directory.php

Milford Care Centre

Complete this on-line form and send to relevant location using the submit buttons at the end of form

Patient' Name:

Date of Birth:

Home Address

Gender: Male: ☐ Female: ☐

Phone:

Mobile:

Current Location:

Patient Living Alone: YES ☐ NO ☐

Next Of Kin if different from Main Carer

Main Carer:

Relationship:

Address:

Telephone:

Name:

Relationship:

Address:

Telephone:

Referral For:

In Patient Admission: ☐

Community Based Services* ☐

Urgency of Referral:
Review or admission requested within*

Two Working Days** ☐ One Week: ☐

Two Weeks: ☐ Pending: ☐

** Subject to triage by specialist palliative care team*
*** Must be accompanied by phone contact from referrer*

Main Diagnosis, treatment to date, further treatment planned: e.g. recent admission(s), radiotherapy, chemotherapy

Active Problem(s) reason(s) for Referral:

PLEASE ATTACH TO SUBMIT EMAIL COPIES OF RECENT CORRESPONDENCE, IMAGING REPORTS AND BLOOD RESULTS

Other Medical Conditions + / - Infection Control Issues (e.g. MRSA)

Patient's Name: Date of Birth:

Current Medications and significant recent changes:

Known Allergies / Drug side effects:

Modified ECOG Performance Status: (Please Tick One)

1. Ambulatory and able to carry out light work. ☐
2. Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ☐
3. Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ☐
4. Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair. ☐

Estimated Prognosis - Please Tick one of the following: Days ☐ Weeks ☐ Months ☐

Awareness of Diagnosis / Prognosis / Referral to Palliative Care:

	Patient		Family / Carer	
Diagnosis	YES ☐	NO ☐	YES ☐	NO ☐
Prognosis	YES ☐	NO ☐	YES ☐	NO ☐
Referral	YES ☐	NO ☐	YES ☐	NO ☐

Any other relevant information (include other contact details, family issues, other health care professionals involved, interpreter required etc.

Referred By: G.P.

Phone / Pager: Phone:

Date: Consultant:

Signed: Hospitals Attended:

Submit to Hospice Referrals | Submit to Hospice at Home Referrals | Reset Form