|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Logo  Description automatically generated with medium confidence | | **Specialist Palliative Care Services Referral Form**  Please forward completed form to your local service provider Contact details available at: [www.icgp.ie/palliative](http://www.icgp.ie/palliative)  <http://www.iapc.idiape-directory.php>  **Milford Care Centre** Download this form and complete. You will need MS Word.  Once complete email to relevant area. See 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 |  | | Name |  | | | | | | |
| Relationship |  | | Relationship |  | | | | | | |
| Address |  | | Address |  | | | | | | |
|  |  | |  |  | | | | | | |
|  |  | |  |  | | | | | | |
|  |  | |  |  | | | | | | |
| Telephone |  | | Telephone |  | | | | | | |
|  |  | |  |  | | | | | | |
| Referral For: | Tick where appropriate | | Urgency of Referral | Review or admission requested within\* | | | | | | |
| In Patient Admission: |  | | Two Working days\*\* | One Week | | Two Weeks | | | Pending | |
|  |  | |  | | |  | |
| Community Based Services\* |  | | \* 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**

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|  |
| **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)** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | |  | | 1. Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours | | | | |  |
|  | | |  | |  | | | | |  |
| 1. Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours | | |  | | 1. 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** | | |
|  | YES | NO | |  | | | | YES | NO | |
| Diagnosis |  |  | | Diagnosis | | | |  |  | |
| Prognosis |  |  | | Prognosis | | | |  |  | |
| Referral |  |  | | Referral | | | |  |  | |

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

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| Referred By: |  | G.P. |  |
| Phone/Pager |  | Phone |  |
| Date |  | Consultant |  |
| Signed |  | Hospital Attended |  |