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| Logo  Description automatically generated with medium confidence | **Specialist Palliative Care Services Referral Form**Please forward completed form to your local service providerContact 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 |
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**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
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|  |  |  |  |
| 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 |  |