Patient’s Name: Home Address:

Date of Birth: Gender: Male Female

Phone

Home: Mobile:

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.icgp.ie/palliative)

[http://www.iapc.ie/iapc—directory.php](http://www.iapc.ie/iapc)

|  |  |
| --- | --- |
| Current Location:  | Patient Living Alone: Yes No |
| Main Carer: Relationship: Address: Phone No: If Main Carer and next of kin are not the same, please add comments/details to *Any other relevent information section on page 2* |
| Referral for:Inpatient unit admission Community based services\*Subject to local availability, services may include OPD, day hospice, Community Specialist Palliative Care Team (“Horne Care Team”) or other | Urgency of Referral:Review or admission requested within\*Two working days” OneweekTwo weeks PendingSubject to triage by specialist palliative care team\*\*Must be accompanied by phone contact from referrer |
| Main Diagnosis, treatment to date, further treatment planned: eg recent admission(s), radiotherapy, chemotherapy,Active problem(s)/reason(s) for referral:PLEASE ATTACH 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:

Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair

4.

Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about mr re than 50\* › of waking hours

Capable of only limited selfcare, confined to bed or chair more than ñ0%. of waking hours

2.

Ambulatory and able to carry out light work

1.

Modified ECOG Performance Status (Please circle one)

|  |  |  |
| --- | --- | --- |
| Estimated prognosis — Please circle 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.):

Hospital(s) attended:

Consultant(s):

Signed:

Aware of Referral: Y / N

Date:

Phone:

Phone / Bleep:

GP:

Referred by:

Referral form available at <http://www.hse.ie/eng/about/Who/clinical/natclinprog/pallcareprog.html>