

SPECIALIST PALLIATIVE CARE REFERRAL FORM

HW005

PRIOR TO REFERRING A PATIENT, PLEASE ENSURE:

1. The patient is aware of the referral
2. There is sufficient supporting information e.g. clinical notes

Please see reverse side for referral criteria.

PATIENT DETAILS (or insert patient label)	
Name	Contact No.
Date of Birth	NHI No.
Patient Email Address	
Address	
First Contact / Next of Kin	Contact No.
GP Name	
GP Email Address	

DIAGNOSIS

RELEVANT OTHER COMORBIDITIES

CLINICAL INFORMATION				
<p>Main reason for referral (please tick applicable):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Medication Review <input type="checkbox"/> Symptom Management <input type="checkbox"/> Psychosocial Support (te taha <i>whanau</i>) <input type="checkbox"/> Mental/Emotional (te taha hinengaro) </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Last Days of Life <input type="checkbox"/> Spiritual/Faith (te taha wairua) <input type="checkbox"/> Physical (te taha tinana) </td> </tr> </table>	<input type="checkbox"/> Medication Review <input type="checkbox"/> Symptom Management <input type="checkbox"/> Psychosocial Support (te taha <i>whanau</i>) <input type="checkbox"/> Mental/Emotional (te taha hinengaro)	<input type="checkbox"/> Last Days of Life <input type="checkbox"/> Spiritual/Faith (te taha wairua) <input type="checkbox"/> Physical (te taha tinana)		
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Referrer Name (please print clearly): Referrer Role Referrer Location Phone/Pager Email	Internal use only: Referral received/actioned by: Date: _____ Time: _____
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Please email this referral to: clinical@hospicewhanganui.org.nz

- This referral is Urgent (24hr response)
 Routine (72 hr response)

Look for two or more general indicators of deteriorating health:

- *Performance status poor or deteriorating, with limited reversibility (needs help with personal care, in bed or chair for 50% or more of the day).*
- *Two or more unplanned hospital admissions in the past 6 months.*
- *Weight loss (5-10%) over the past 3-6 months and/pr body mass index <20.*
- *Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).*
- *Patient requests supportive and palliative care, or treatment withdrawal.*

Look for any clinical indicators of advanced conditions

CANCER

- Functional ability deteriorating due to progressive metastatic cancer
- Too frail for oncology treatment or treatment is for symptom control

DEMENTIA/FRAILITY

- Unable to dress, walk or eat without help
- Choosing to eat and drink less; difficulty maintaining nutrition
- Urinary and faecal incontinence
- No longer able to communicate using verbal language, little social interaction
- Fractured femur; multiple falls
- Recurrent febrile episodes or infections; aspiration pneumonia

HEART/VASCULAR DISEASE

- NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:
 - Breathlessness or chest pain at rest or on minimal exertion
- Severe, inoperable peripheral vascular disease

KIDNEY DISEASE

- Stage 4 or 5 chronic kidney disease (eGFR <30ml/min) with deteriorating health
- Kidney failure complicating other life limiting conditions or treatment
- Stopping dialysis

LIVER DISEASE

- Advanced cirrhosis with one or more complications in the past year:
 - Diuretic resistant ascites
 - Hepatic encephalopathy
 - Hepatorenal syndrome
 - Bacterial peritonitis
 - Recurrent variceal bleeds
- Liver transplant is contraindicated

NEUROLOGICAL DISEASE

- Progressive deterioration in physical and/or cognitive function despite optimal therapy
- Speech problems with increasing difficulty communicating and/or progressive dysphagia
- Recurrent aspiration pneumonia; breathless or respiratory failure

RESPIRATORY DISEASE

- Severe chronic lung disease with:
 - Breathlessness at rest or on minimal exertion between exacerbations
- Needs long term oxygen therapy
- Has needed ventilation for respiratory failure or ventilation is contraindicated