SPECIALIST PALLIATIVE CARE REFERRAL FORM

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

Patient Details

Name:	**Date of Birth:**	**Gender:** Male Female
Address:	**Phone:**	**Medical Card:** Yes No
	Mobile:	**Health Ins:** Yes No

Current Location:	**Is the Patient Living Alone?** Yes No

Contact Person

Contact Person (Family/Friend):	**Address:**
Relationship:	**Phone:**

Referral For:

Hospice Admission: ☐
Community Based Services*: ☐
Hospital OPD: ☐
Other: ☐

*Subject to availability, services may include OPD, Day Hospital, Community Specialist Palliative Care Team (Home Care Team) or other.

Urgency of Referral:
(Subject to Triage by Specialist Palliative Care Team)

Two working days* ☐
*Must be accompanied by phone contact from Referrer
One Week ☐
Two Weeks ☐
Pending ☐

Diagnosis, treatment to date, further treatment planned (e.g. recent admission(s), radiotherapy, chemotherapy, etc.)
PLEASE ATTACH COPIES OF RECENT CORRESPONDENCE, IMAGING REPORTS AND BLOOD RESULTS

Active Problem(s)/Reason(s) for Referral:

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

Patient's Name: **Date of Birth:**

Current Medication - Dosage and Significant Recent Changes:

Known Allergies/Drug Side-Effects:

Performance Status:

(Please tick which applies)

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

Estimation of Prognosis:: **Days** ☐ **Weeks** ☐ **Months** ☐

(Please tick one)

Awareness of diagnosis/prognosis/referral to palliative care:

	Patient		**Family and/or 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):

PLEASE COMPLETE IN BLOCK CAPITALS

GP: **GP Phone:** **GP Address:** **GP Aware of Referral**: Yes No	**Consultant(s):**	**Referred By:** **Job Title:** **Place of Work:** **Phone:**

Date:

Signature: