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|  | **NATIONAL SPECIALIST PALLIATIVE CARE REFERRAL FORM**  Please forward the completed form to your local service provider.  Service Provider contact details available at:  [Local Services - IAPC](https://iapc.ie/referral-local-services/)  Click [Online Referral Form](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/referring/) for further copies  Click here for the [Eligibility Criteria for SPC Services - access and discharge](https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/eligibility-criteria-for-access-to-discharge-from-specialist-palliative-care-services.pdf)  Click here for the [Palliative Care Needs Assessment Guidance](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/needs-assessment-guidance/palliative-care-needs-assessment-guidance-2411.pdf) |

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| **Patient Details** | | | |  |  |
| **Name:** **Address:** | **Date of Birth:** Enter a date     **Contact Tel Nos.:** | | **Sex at Birth:** Select  **Preferred Language:**  **Translator Required:** Select | | |
| **Eircode:** | **PPSN No.:** | | **Medical Card:** Select  **Medical Card No.** (If applicable): | | |
| **Current Location:** | **Patient Lives Alone?:** Select | | | |  |
| **Main Contact Person – Family/Carer/Representative** | | | | | |
| **Contact Name:**  **Relationship:**  **Eircode:** | | **Phone No.:**  **Address:** | | | |
| **First Contact in an emergency (if not the above):** **Phone No.:**  **Relationship:** | | | | | |
| **Referral for which Specialist Palliative Care Service:**  Admission to Hospice/Inpatient Unit\*  Community Based Services\*/\*\*   Hospital Inpatient Review  Hospital Outpatient Review  Other:  \*Subject to triage & availability. \*\*May also include OPD, SPC Day Unit, or other. | **Urgency of Referral:**  (Subject to Triage by Specialist Palliative Care Team)  Within Two working days\*  \*Referral must be accompanied by phone call from referrer  Within One Week  Within Two Weeks  For Information Only | | | | |
| **Diagnosis, (cancer or non-cancer) previous and current treatments, recent hospital admissions & future treatment plans.**  Please attach relevant correspondence, bloods, and imaging results. Incomplete information may delay triage and first assessment. **Future Care Plan/Treatment Escalation Plan in place** Select **If yes, please describe:**  **Advance Healthcare Directive in Place**: Select **DNACPR decision in Place**: Select | | | | | |
| **Active or anticipated problem(s)/reason(s) for referral:** Consider Physical, Psychological, Spiritual, Social, Family/Carer domains | | | | | |
| **Other Medical Conditions +/- Infection Control issues** (e.g., MRSA, VRE, CPE, KPC, others): | | | | | |

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| **Patient’s Name:** **Date of Birth:** Enter a date **PPS No.:** | | |
| **Current Medications – doses and significant recent changes:** | | |
| **Known drug allergies/ Side-effects/Sensitivities to medications/dressings etc.:** | | |
| **Equipment/devices currently in use** | | |
| Long Term O2 Therapy: Select Non-Invasive Ventilation: Select Tracheostomy: Select | Active Implantable Cardioverter Defibrillator (ICD): Select IV Access/Port (If other please specify): Select Other:       Clinical Equipment (If other please specify): Select Other:       Miscellaneous Equipment (If other please specify): Select Other:  A  Clinical Equipment (If other please specify):  (if other please specify) Choose an item. | |
| **Australian-Modified Karnofsky Performance Status (AKPS):** Select | | |
| **Estimation of Prognosis: Awareness of diagnosis, prognosis, and referral to specialist palliative care** | | |
| **Estimation of Prognosis:** (Please tick one) **Days**  **Weeks**  **Months**  **Years**  **Patient aware?: Are Family and/or Carer aware?:**  **Diagnosis**: Select **Diagnosis**: Select  **Prognosis**: Select **Prognosis**: Select  **Referral**: Select **Referral**: Select | | |
| **Any other relevant information:** (e.g., other contact details, family or other domestic issues of concern, other health care professionals involved, etc.) | | |
| **Details of GP and Consultants involved in the patient’s care.** | | |
| **GP’s Name:**  **GP’s Phone:**  **GP’s Address:**  **GP Aware of Referral**: Select  **Is the GP content to complete a death notification form in the event of an anticipated death?:**  Select  Click or tap here to Enter text. | | **Consultant’s Name(s):**  **Hospital Location(s):** |
| **Referred by:**  **Name:**  **Job Title:**  **Place of Work:**  **Contact Tel No/Bleep:** | | **Referrer’s Signature:** **Referrer’s Registration No:** **Date:** Enter a date. |

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