NSW METRO (660) PALLIATIVE CARE HOME SUPPORT PACKAGES (PEACH) PROGRAM REFERRAL FORM

Clear Form

Triple I Hub **Telephone: 1800 455 511** **Fax: (02) 4621 8799** **Email: triplei@sswahs.nsw.gov.au**

LHD: **SWSLHD** ☐ **WSLHD** ☐ **SLHD** ☐ **ISLHD** ☐ **NBMLHD** ☐

Request date for first visit: _____ **CNCM aware of same day referral: YES** ☐ **NO** ☐ **N/A** ☐

CLIENT DETAILS:

Surname: _____ First name/s: _____ Title: _____

Date of Birth: _____ MRN: _____ Interpreter needed: No ☐ Yes ☐ Language: _____

Address for service delivery: _____

Aboriginal ☐ Torres Strait Islander ☐

CARER DETAILS:

Name of Main Carer: _____ Relationship to client: _____

Preferred Contact Number: _____ Alternate Phone Number: _____

Guardian/Person Responsible: _____ Phone No: _____

Interpreter needed: No ☐ Yes ☐ Language: _____

MEDICAL HISTORY:

PCOC Phase: _____ Karnofsky score: _____

Preferred place for End for Life Care: Home ☐ PCU ☐ Hospital ☐ Undecided ☐

WORK HEALTH AND SAFETY:

Any Risks Identified: No ☐ Yes ☐ (specify): _____ Hospital Bed available: Yes ☐ No ☐ Ordered ☐

MRO/Infectious Disease (please specify) _____

MEDICATIONS:

Original Medication Chart available in client's home: Yes ☐ No ☐ To be arranged ☐ (attach if available)

Sub cut meds available in the home: Yes ☐ No ☐ To be arranged ☐

REFERRER/MEDICAL GOVERNANCE DETAILS:

Referred by: _____ Designation: _____ Phone No: _____ Date: _____

Referral Source: _____ Hospital: ED ☐ Ward ☐ PCU ☐ **Or** _____ Community Health Centre

Referral Approved By: _____ Designation: _____

GP Name (Medical Governance): _____ Phone No: _____ Fax: _____

After Hours available Yes ☐ No ☐ Phone No: _____

Alternate A/H Service & Phone No: _____

Handover to be sent to: _____ **Fax:** _____ **Phone No:** _____

Intake Service/Community Health Centre

ATTACHMENTS:

MANDATORY: Care Plan OR Nursing Assessment ☐ Home Safety Checklist ☐ PCOC Assessment **OR** Discharge Summary ☐

IF AVAILABLE: Recent clinical notes ☐ Recent GP or specialist letters ☐ Verification of Death Form ☐ Ambulance Care Plan ☐

Advance Care Plan ☐ Expected Death at Home Form ☐ Funeral Director selected by family ☐

Silver Chain

Clear Form

CARE PLAN

DATE: _____

CLIENT DETAILS:

Surname: _____ First name/s: _____ Title: _____ Date of Birth: _____

Shower ☐ Bed Sponge ☐ Own Teeth ☐ Dentures ☐

Urine: Continent ☐ Incontinent ☐ IDC ☐ SPC ☐ Date last changed _____

Bowels: Continent ☐ Incontinent ☐ Date last opened _____

Comments:

SYMPTOMS:

Please tick boxes where applicable

Pain ☐ Site _____ Subcutaneous Medications ☐ Oral Meds ☐

Syringe Driver ☐ In Progress ☐ To Commence ☐ Enema Authority ☐ Aperients ☐

Nausea ☐	Candidiasis ☐	Lymphoedema ☐	Delirium ☐
Vomiting ☐	Mouth Ulcers ☐	Anxiety ☐	Headaches ☐
Constipation ☐	Dyspnoea ☐	Fatigue ☐	Seizures ☐
Diarrhoea ☐	Cough ☐	Sleep Disturbance ☐	Agitation ☐
Dry Mouth ☐	Secretions ☐	Confusion ☐	Existential distress ☐

MANAGEMENT PLAN (PROVIDE DETAILS):

☐ Lines insitu: _____

☐ Oxygen Therapy: _____

☐ Drains: _____

☐ Wounds (incl pressure injury): _____

☐ Pacemaker / Implantable device: _____
Plans for deactivation: Yes ☐ No ☐

☐ Psychosocial: _____

☐ Spiritual needs identified: _____

☐ Religious preferences: _____

☐ Cultural Needs: _____

☐ Carer / Family concerns: _____

☐ Support systems / services in place: _____

☐ Plan for predictable catastrophic event: _____

☐ Carer educated on what to do when death occurs: _____

☐ Carer educated on administration of SC breakthrough: _____

☐ Mobility: _____

Other: _____

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