Feidhmeannacht na Seirbhise Sainte
Health Service Executive

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.iapc.idiape-directory.php

Please Fax Completed Form to **Milford Care Centre, Limerick** on
For In-Patient Care: **061 201 725**
For Hospice at Home: **061 485 849**

Patient's Name: …… Home Address: …….. …… ……	Date of Birth …… Gender: Male ☐ Female ☐ Phone: Home:…… Mobile: ……..

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 relevant information section on Page 2

Referral for: In-Patient unit admission ☐ Community based services* ☐ **Subject to local availability, services may include OPD, day hospice, Community Specialist Palliative Care Team ("Home Care Team") or other*	Urgency of Referral: Review or admission requested within* Two working days** ☐ One Week ☐ Two Weeks ☐ Pending ☐ **Subject to triage by specialist palliative care team* ***Must be accompanied by phone contact from referrer*

Main Diagnosis, treatment to date, further treatment planned: e.g. 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:

Modified ECOG Performance Status (Please circle one)

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

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.

Referred By:	G.P.
Phone / Bleep	Phone:
Date:	Aware of Referral: Y / N
Signed:	Consultant(s):
	Hospital(s) attended:

Referral form available at http://www.hsele/eng/about/Who/clinical/natclinprog/pallcareprog.html