REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**SUPPORTIVE AND SPECIALIST PALLIATIVE CARE CLINIC**

Correspondence template for new referrals and existing patients

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| **SEND TO** Dr Andrew Broadbent (Community Palliative Care)Supportive and Specialist Palliative Care Service**Phone** 1300 763 218**Fax** 07 5668 6759  | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:**  |

**If the matter is urgent please telephone the community CNC on 1300 763 218 or the on-call consultant on 5668 6000 if the patient requires admission.**

Dear Dr Broadbent

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:****Address:** **Home Ph**: **Mobile Ph:** **Medicare Number\*:** (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:** **Next of Kin/Alternative Contact Ph:** **Does patient identify as Aboriginal and/or Torres Strait** **Islander:** **Interpreter required:** **If yes, specify language:**  |

Patient/decision maker agreeable to palliative care referral:

What is the patient's current location:

**SECTION 2 Reason for referral and additional clinical information**

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| What is the reason for referral:Please provide provisional diagnosis (if available): Please include any symptoms and date of onset (if known):**Paste or type relevant history, clinical examination findings and treatment to date if required**Assessment and provision of service:If yes, please specify**:** To set or achieve care goals: If yes, please specify: Patient needs exceed primary care capacity/resources: If yes, please specify: Difficulty maintaining place of residence: If yes, please specify: Care at the end of life requirements:If yes, please specify: |

**SECTION 3 Mandatory clinical information**

Patient has cancer or other life limiting illness:

If yes, please specify:

Estimated prognosis: eg days weeks months years:

Are NGOs or allied health/other providers involved in current care:

If yes, please specify:

Is there an Advanced Health Directive in place:

If yes, please specify:

Does the patient have a Statement of Choices:

If yes, please specify:

Does patient have an Enduring Power of Attorney:

If yes, please specify:

Are you able to do home visits:

If no, please specify barriers:

Are you available to do teleconferences:

If yes, please specify:

**SECTION 4 Investigations**

*Please attach any investigation relevant results regarding the disease and severity including blood tests, MRIs, CT and pathology results.*

**SECTION 5 Duration of referral**

Please indicate how long you would like your referral to remain valid:

[ ]  12 months

[ ]  Indefinite

Indefinite referrals do not expire until the patient has been discharged by the hospital service. When referrals expire, there is an expectation that the referring GP or another GP will review the care of the patient. If the patient still requires specialist care, the GP will then have to request a referral continuation.

**SECTION 6 Social factors and impact on the patient**

*Consider the impact on activities of daily life; ability to care for others; personal safety/frailty; other factors.*

***Please paste or type relevant information.***

**SECTION 7 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **CNCs/SMOs/VMOs in this Specialist Service** |

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| Dr Andrew Broadbent (Director) | Dr Joanne Doran | Dr Graham Grove |
| Dr Nicola Morgan | Ms Julie Barnes (CNC) | Ms Jodie Morris (CNC) |
| Ms Julie Murphy (CNC) | Ms Helen Gullison (CNC) |  |