Canberra Health Services | ACT Government

Clare Holland House

PALLIATIVE CARE REFERRAL FORM

Complete details or affix label

MRN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

This form is only to be used in cases where the referrer does not have access to submit a referral through DHR or HealthLink SmartForm.	Triage team should contact to discuss the referral: Name: _____ Phone Number: _____

Does the patient have *(tick & attach if available)*

- ☐ EPOA/Medical treatment decision maker
- ☐ Goals of care decision
- ☐ Health direction/statement of choices(ACD)

Current Goals of Care

☐ All Life Sustaining	Aims to extend life, pursuing cure or remission, with full interventions & resuscitation.
☐ Life Extending	Intensive life-prolonging treatment with predefined limits, balancing aggressive care, quality of life, and avoiding non-beneficial interventions.
☐ Active Ward Based	Active medical treatment within a ward setting, open to trial of simple treatments with a focus on symptom management & comfort.
☐ Optimal Comfort	Comfort-focused end-of-life care prioritizing dignity, symptom relief, and emotional support, without life-prolonging treatments or resuscitation.

Estimated prognosis *(tick one)* ☐ Days ☐ Weeks ☐ 6 - 12 Months ☐ 12+ Months ☐ Unknown

Patient aware of: ☐ Diagnosis ☐ Prognosis ☐ Referral to palliative care

Family/carer/contact person aware of: ☐ Diagnosis ☐ Prognosis ☐ Referral to palliative care

Patient/EPOA has consented for referral to:	**Urgency of referral**
☐ Clare Holland House Inpatient unit **Ph: (02) 5103-7300**	☐ Urgent: 24 - 48 Hours; (rapidly deteriorating or in terminal/ dying phase) *Call relevant area (contact numbers on the left)*
☐ Outpatient or Home Based Services **Ph: (02) 5103-7333**	☐ Unstable: One Week; (patient experiencing distressing physical and/or psychosocial symptoms not responding to established palliative care management/protocols)
☐ Residential Aged Care (PEACE Team) **Ph: 0413 611 320**	☐ Stable: More than one week; (patient stable but seeking palliative care information and support)
☐ Discussion with GP (PEACE ONLY)	

Main palliative diagnosis, relevant history and current management

Please attach a patient summary with copies of recent medical correspondence, recent screening/imaging and blood tests where relevant.

_____

_____

_____

_____

_____

_____

_____

DO NOT WRITE IN THIS BINDING MARGIN
DO NOT PHOTOCOPY AS A TEMPLATE

PALLIATIVE CARE REFERRAL FORM 25370

25370(0926)

Canberra Health Services | ACT Government

Clare Holland House

PALLIATIVE CARE REFERRAL FORM

Complete details or affix label

MRN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Symptoms - Patient has consistent moderate or severe symptoms of:

☐ Poor Appetite ☐ Bowels ☐ Urine ☐ Fatigue ☐ Mobility ☐ Nausea ☐ Pain

☐ Persistent Cough ☐ Breathing ☐ Sleep ☐ Other: _____

What is the trigger for palliative care referral?

☐ 1. Symptom assessment and management ☐ 2. Terminal phase ☐ 3. Psychosocial symptoms

Details: _____

_____

_____

Australian modified Karnofsky Performance Scale (AKPS) *(tick one):*

☐	100 Normal, no complaints or evidence of disease	☐	50 Considerable assistance and frequent medical care required
☐	90 Able to carry on normal activity, minor signs of illness present	☐	40 In bed more than 50% of the time
☐	80 Normal activity with effort, some signs or symptoms of disease	☐	30 Almost completely bedfast
☐	70 Able to care for self, but unable to work or carry on other normal activities	☐	20 Totally bedfast & requiring nursing care by professionals and/or family
☐	60 Able to care for most needs but requires occasional assistance	☐	10 Comatose, or barely rousable

Name of Referrer: _____ Signature: _____ Date: _____

Provider Number: _____

PEACE referrals: Email completed forms to PEACE@act.gov.au

All other referrals: Email completed forms to CHSNCH.CSPCS@act.gov.au

Fax: Completed forms can also be faxed to Clare Holland House on (02) 5103 7301.

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