Grampians Regional
Palliative Care Team

Triage: 0408 612 699 **Pager**: 03 5320 4000 P #4607

REFERRAL FORM

Attach Bradma label here, or complete details.

Hospital UR#: .....

Surname: .....

Given Name: .....

Address: .....

Suburb: ..... Post Code: .....

DOB: ..... Sex: .....

Referral Date: .....

Referrer's Name: .....

Referrer's Contact No: .....

Clinical Role: .....

Ward/Location: .....

Health Service/Organisation: .....

Medicare number: .....

Phone: .....

Language if other than English: .....

Specific communication needs: .....

Sector: ☐ Acute ☐ Sub-Acute ☐ Community

Locality: ☐ Ararat ☐ Bacchus Marsh ☐ Ballarat ☐ Horsham ☐ Other

SELECT ONE REFERRAL OPTION

☐ REFERRAL OPTION 1

GRAMPIANS REGIONAL PALLIATIVE CARE TEAM

☐ **Nursing / Team** ➜ *Complete Page 1*
OR
☐ **Specialist Medical / NP** ➜ *Complete Pages 1 & 2*

Forward completed referral form to:
Central Intake Fax 5320 3893 (Ph 5320 6690)

☐ REFERRAL OPTION 2

PALLIATIVE CARE OUTPATIENT CLINIC

➜ Complete Pages 1 & 2 ***or*** Smart Referral ***or*** letter to physician.

If referring from BHS, **MR/005.99** is preferred.

Forward completed referral form to:
BHS Outpatient Clinic Fax 5320 3080 (Ph 5320 8500)

Reason for Referral: ☐ Complex/Poorly Controlled Symptoms ☐ Terminal Care ☐ Deteriorating ☐ Discharge Planning
☐ Gandarra Admission ☐ Case Conference ☐ Other - please specify: .....

Level of urgency: ..... **Goals of care**: .....

Diagnosis: ..... ☐ Malignant ☐ Non-malignant

What is your primary concern for this assessment? .....

.....

.....

Current symptoms/treatment: .....

.....

.....

.....

.....

Relevant Patient History (or PTO to complete Past Medical History): .....

.....

Is Patient / Family aware of referral? ☐ Yes ☐ No

For Inpatients: Is Medical Team aware of referral? ☐ Yes ☐ No **Which Team?** .....

For Community / Residential patients: Is GP aware of referral? ☐ Yes ☐ No **GP Name:** .....

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Hospital UR#: .....

Surname: .....

Given Name: .....

DOB: .....

Past Medical History:

Relevant Clinical Information: **Please attach relevant medical letters or information including scans and pathology**.

Current Medications:

Allergies:

Other Healthcare Providers:

FOR REFERRAL TO OUTPATIENT CLINIC PLEASE COMPLETE THE SECTION BELOW

Palliative Care Outpatient Clinic, Ballarat Health Services
Consultant: Dr Eve Westland

Referring doctor's name: .....

Doctor's signature: .....

Provider number: .....

Phone: .....

Practice name & address: .....