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|  | **NATIONAL SPECIALIST PALLIATIVE CARE REFERRAL FORM**Please forward the completed form to your local service provider. Service Provider contact details available at: [Local Services - IAPC](https://iapc.ie/referral-local-services/) Click [Online Referral Form](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/referring/) for further copiesClick here for the [Eligibility Criteria for SPC Services - access and discharge](https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/eligibility-criteria-for-access-to-discharge-from-specialist-palliative-care-services.pdf)Click here for the [Palliative Care Needs Assessment Guidance](https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/needs-assessment-guidance/palliative-care-needs-assessment-guidance-2411.pdf) |

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| **Patient Details** |   |   |
| **Name:** **Address:**  | **Date of Birth:** Enter a date   **Contact Tel Nos.:**  | **Sex at Birth:** Select**Preferred Language:** **Translator Required:** Select |
| **Eircode:**  | **PPSN No.:**  | **Medical Card:** Select **Medical Card No.** (If applicable): |
| **Current Location:**  | **Patient Lives Alone?:**Select  |   |
|  **Main Contact Person – Family/Carer/Representative** |
|  **Contact Name:**  **Relationship:**  **Eircode:**  | **Phone No.:** **Address:**  |
| **First Contact in an emergency (if not the above):** **Phone No.:**  **Relationship:**  |
|  **Referral for which Specialist Palliative Care Service:**[ ]  Admission to Hospice/Inpatient Unit\* [ ]  Community Based Services\*/\*\* [ ]  Hospital Inpatient Review [ ]  Hospital Outpatient Review [ ]  Other:  \*Subject to triage & availability. \*\*May also include OPD, SPC Day Unit, or other. | **Urgency of Referral:**(Subject to Triage by Specialist Palliative Care Team)[ ]  Within Two working days\* \*Referral must be accompanied by phone call from referrer [ ]  Within One Week [ ]  Within Two Weeks [ ]  For Information Only |
| **Diagnosis, (cancer or non-cancer) previous and current treatments, recent hospital admissions & future treatment plans.**  Please attach relevant correspondence, bloods, and imaging results. Incomplete information may delay triage and first assessment. **Future Care Plan/Treatment Escalation Plan in place** Select **If yes, please describe:**  **Advance Healthcare Directive in Place**: Select **DNACPR decision in Place**: Select |
| **Active or anticipated problem(s)/reason(s) for referral:** Consider Physical, Psychological, Spiritual, Social, Family/Carer domains  |
| **Other Medical Conditions +/- Infection Control issues** (e.g., MRSA, VRE, CPE, KPC, others):  |

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| **Patient’s Name:** **Date of Birth:** Enter a date **PPS No.:**  |
| **Current Medications – doses and significant recent changes:**  |
| **Known drug allergies/ Side-effects/Sensitivities to medications/dressings etc.:**  |
| **Equipment/devices currently in use** |
| Long Term O2 Therapy: Select Non-Invasive Ventilation: Select Tracheostomy:Select   | Active Implantable Cardioverter Defibrillator (ICD): Select IV Access/Port (If other please specify): Select Other:       Clinical Equipment (If other please specify): Select Other:       Miscellaneous Equipment (If other please specify): Select Other:        AClinical Equipment (If other please specify): (if other please specify) Choose an item. |
| **Australian-Modified Karnofsky Performance Status (AKPS):** Select |
| **Estimation of Prognosis: Awareness of diagnosis, prognosis, and referral to specialist palliative care** |
| **Estimation of Prognosis:** (Please tick one) **Days** [ ]  **Weeks** [ ]  **Months** [ ]  **Years**  [ ] **Patient aware?: Are Family and/or Carer aware?:****Diagnosis**: Select **Diagnosis**: Select**Prognosis**: Select **Prognosis**: Select**Referral**: Select **Referral**: Select  |
| **Any other relevant information:** (e.g., other contact details, family or other domestic issues of concern, other health care professionals involved, etc.)     |
| **Details of GP and Consultants involved in the patient’s care.** |
| **GP’s Name:** **GP’s Phone:** **GP’s Address:**  **GP Aware of Referral**: Select **Is the GP content to complete a death notification form in the event of an anticipated death?:**  Select Click or tap here to Enter text. | **Consultant’s Name(s):** **Hospital Location(s):**  |
| **Referred by:** **Name:** **Job Title:** **Place of Work:** **Contact Tel No/Bleep:**  | **Referrer’s Signature:** **Referrer’s Registration No:** **Date:** Enter a date. |

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