



Facility: COM HKH MQE MVH RNS RYD

NURSE PRACTITIONER PALLIATIVE CARE REFERRAL

FAMILY NAME		MRN
GIVEN NAME		MALE FEMALE
D.O.B. DD / MM / YYYY	M.O.	
ADDRESS		
		PH
M/C	FIN	
LOCATION / WARD		ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Palliative Aged Care Cardiac Supportive Care

Patient Location Date: ___ / ___ / ____

Consent for referral: Patient Person responsible

Are you of Aboriginal or Torres Strait Islander Origin? Yes - Aboriginal Yes - Torres Strait Islander
Yes - both Neither Unknown

Person Responsible Relationship

Contact Number

Language: Interpreter required: Yes No

GP Name

Phone Fax Is GP aware of referral? Yes No

Is the patient seen by other palliative care service? Yes No

If Yes

Referral Type: Urgent (Please call to discuss) Non Urgent/Routine

Reason for Referral: Symptom control Terminal care Psychosocial support Complex End of Life Planning

Diagnosis and Treatment (previous & current):	Medical History:

Advance Care Plan or Directive completed: Yes No Unkown

Functional Status: Independent Partial Assist Full assist

Patient and Family Concerns/Goals of Care:

Please attach any relevant medical document

Medication chart Recent pathology or investigation report Advance Care Plan/Directive
Medical notes Recent Hospital discharge summary Echo report

Referring Facility

Referrer's Name Position

Email Phone Fax

Please email completed referral to: NSLHD-ReferralPalliativeCare@health.nsw.gov.au

Palliative Aged Care Fax: 02 9463 2045 Hornsby Ku-ring-gai LGA -0427 353 387 Northern Beaches LGA -0457 484 556 Lower North Shore/Ryde/Hunters Hill -0457 495 251	Cardiac Supportive Care Fax: 02 9463 2045 Northern Sydney Local Health District -0427 312 302
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Office Use Only - Date referral received: ___ / ___ / ____

Holes punched as per AS2828.1:2019

BINDING MARGIN - NO WRITING

COR5278

CATALOGUE NUMBER NS12988-E AUG24/VI

REFERRAL - NP PALLIATIVE CARE