Northern Sydney
Local Health District

Facility: COM HKH MQE MVH RNS RYD

ADOLESCENT & YOUNG ADULT HOSPICE (AYAH) 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

Referring Medical Officer to complete Date completed: __ / __ / ____

Patient Information

Name .....

Date of birth: __ / __ / ____ Age ..... Sex: .....

Is the patient of Aboriginal or Torres Strait Islander Origin? ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – both ☐ Neither ☐ Unknown

Primary diagnosis:

Other diagnosis or issues relevant to medical care:

Reason for admission:

☐ Respite ☐ Symptom control ☐ End of Life Care ☐ Other (specify) .....

Medical Officer's name .....

Address .....

Phone ..... Fax ..... Email .....

During the patient's admission to the Adolescent and Young Adult Hospice, if further medical information about the patient is required, who is the main treating specialist to be contacted and who will accept the patient's care after they have been discharged from the Adolescent and Young Adult Hospice?

Name ..... Position .....

Is the patient known to specialist palliative care? If yes, provide details

Specialist name ..... Phone .....

GP name ..... Phone .....

Past Medical History

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Current physical state

Weight ..... kg

Neurological:

Musculoskeletal:

Cardiovascular:

Respiratory (incl CPAP settings):

Gastrointestinal (constipation issues, PEG, feeding methods):

Genitourinary:

Skin:

Infection status (e.g. MRO):

Holes punched as per AS2828.1:2019
BINDING MARGIN – NO WRITING

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Social/family issues

Parents/Guardians:

Name ..... Relationship .....

Name ..... Relationship .....

For those **aged 15 - 17** who has legal responsibility for the patient?

For those **18 and over** who is the person responsible?

This patient has a life limiting illness which will more than likely result in premature death. ☐ Yes ☐ No

Current PCOC phase: ☐ Stable ☐ Unstable ☐ Deteriorating ☐ Terminal ☐ Bereavement - post death support

Does this patient have an Advance Care Plan or Advance Care Directive? ☐ Yes ☐ No

If yes, please include a copy with this referral.

On admission to the Adolescent & Young Adult Hospice, the patient and carers will be asked what they would like to happen in the event of any deterioration (eg transfer to hospital) It is often helpful for us to know if end of life issues have been discussed or the issue broached with the patient and family before. Have these discussions taken place and what has the extent of them been?

Holes punched as per AS2828.1:2019
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Medication

Please provide details of all current medications below or attach as a separate list. Please print clearly.

Allergies

Recent Investigations (e.g. imaging and blood tests. Attach if applicable.)

Medical Officer name ..... Signature .....

Designation ..... Date: __ / __ / ____

Return this completed form to: Adolescent and Young Adult Hospice
Email: NSLHD-AYAHMANLY@health.nsw.gov.au