Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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
Click Online Referral Form for further copies
Click here for the Eligibility Criteria for SPC Services - access and discharge
Click here for the Palliative Care Needs Assessment Guidance

Patient Details		
Name: **Address:** **Eircode:**	**Date of Birth:** Enter a date **Contact Tel Nos.:** **PPSN No.:**	**Sex at Birth:** Select **Preferred Language:** **Translator Required:** Select **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): **Relationship:**	**Phone No.:**

Referral for which Specialist Palliative Care Service:	**Urgency of Referral:** (Subject to Triage by Specialist Palliative Care Team)
☐ 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.	☐ 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):

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 O_2 Therapy:	Select	Active Implantable Cardioverter Defibrillator (ICD):	Select	
Non-Invasive Ventilation:	Select	IV Access/Port (If other please specify):	Select	Other:
Tracheostomy:	Select	Clinical Equipment (If other please specify):	Select	Other:
		Miscellaneous Equipment (If other please specify):	Select	Other:

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:	**Consultant's Name(s):**
GP's Phone:	
GP's Address:	**Hospital Location(s):**
GP Aware of Referral: Select	
Is the GP content to complete a death notification form in the event of an anticipated death?: Select	
Referred by:	**Referrer's Signature:**
Name:	**Referrer's Registration No:**
Job Title:	**Date:** Enter a date.
Place of Work:	
Contact Tel No/Bleep:	