Please fax completed form to: 3112 4236

(Affix identification label here)

Family name:

Given name (s):

Address:

Date of Birth: Sex: M F

Name of Facility:

....

Wing/Area: ....

Country of Birth:

Aboriginal/Torres Strait Islander Yes / No

Name of Referrer: ....

Referral Date: .... / .... / .... **Contact No:** ....

Diagnosis / Medical Condition: ....

....

....

Urgent Referral (24-48 hrs) * **Priority Referral (2-3 days) *** **Non-urgent Referral (7 days)**

*** (NB. Phone contact is required for <u>Urgent</u> or <u>Priority</u> referrals Phone: 0477755607**

Email: admin@cimas.net.au

Reason for Referral:

Pain (please commence pain assessment prior to Palliative Care Referral)

End of Life symptom management (experiencing complex EOL care issues)

Family conference / support with care planning (requires the participation by a member(s) of RACF team, GP, family)

Other symptoms / issues (please specify):...

Describe the problems / issues: ....

....

....

Checklist:

- Has the GP been consulted and consented to referral (mandatory to ascertain)? Yes No
- Resident / EPOA / adult guardian consent to Palliative Care support? Yes No

Supporting documentation (Please attach)

- Current medications
- Medical Summary

General Practitioner Name: ....

Clinic Name: ....

Phone: .... **Fax No.:** ....