



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## Specialist Palliative Care Service Referral Form

Please forward completed form to your local service provider

Contact details available at:

**[www.icgp.ie/palliative](http://www.icgp.ie/palliative)**

<http://www.iapc.ie/iapc-directory.php>

Patient's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: Male  Female

Phone

Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

Current Location: \_\_\_\_\_

Patient Living Alone: Yes  No

Main Carer: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

\_\_\_\_\_

If Main Carer and next of kin are not the same, please add comments/details to *Any other relevant information section on page 2*

### Referral for:

Inpatient unit admission

Community based services\*

\* Subject to local availability, services may include OPD, day hospice, Community Specialist Palliative Care Team ("Home Care Team") or other

### Urgency of Referral:

Review or admission requested within\*

Two working days\*\*

One week

Two weeks

Pending

\*Subject to triage by specialist palliative care team

\*\*Must be accompanied by phone contact from referrer

**Main Diagnosis, treatment to date, further treatment planned:** eg recent admission(s), radiotherapy, chemotherapy,

**Active problem(s)/reason(s) for referral:**

**PLEASE ATTACH COPIES OF RECENT CORRESPONDENCE, IMAGING REPORTS AND BLOOD RESULTS**

**Other Medical Conditions +/- Infection Control Issues (e.g. MRSA)**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Current medications and significant recent changes:**

**Known allergies / drug side effects:**

**Modified ECOG Performance Status (Please circle one)**

1. Ambulatory and able to carry out light work
2. Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3. Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4. Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair

**Estimated prognosis – Please circle one of the following:**      **Days**                      **Weeks**                      **Months**

**Awareness of diagnosis / prognosis / referral to palliative care :**

	<b>Patient</b>	<b>Family / Carer</b>
<b>Diagnosis</b>	Yes / No	Yes / No
<b>Prognosis</b>	Yes / No	Yes / No
<b>Referral</b>	Yes / No	Yes / No

**Any other relevant information (include other contact details, family issues, other health care professionals involved, interpreter required etc.):**

**Referred by:**

**GP:**

**Phone / Bleep:**

**Phone:**

**Date:**

**Aware of Referral: Y / N**

**Signed:**

**Consultant(s):**

**Hospital(s) attended:**