Government of Western Australia
Department of Health
WA Cancer and Palliative Care Network

Specialist Palliative Care Service Referral Form

NB – If referral is urgent a phone call is required

Referral criteria for eligibility: See WA Health Department *Referral to Specialist Palliative Care* (click to link)		
Referral date: / /	**Date referral acknowledged** (office use only): / /	
Date ready for care: / /	**Referral made to** (name of service):	
Referral source		
Name of referrer:	**Provider No:**	**Phone No:**
Position/Organisation:		**Ward/Unit** (if relevant):
General Practitioner:	**GP Phone No:**	**GP Fax No:**
Patient details		
Last name:	**First/middle names:**	
Date of birth: / /	**Sex**: ☐ M ☐ F ☐Indeterminate	
Address:		**Post code:**
Home phone:	**Mobile:**	**Lives alone:** ☐Yes ☐No
Medicare no:	**Medicare expiry date:** / /	**DVA no:**
Country of birth:	**Australian resident:** ☐Yes ☐No	
Preferred language:	**Interpreter required:** ☐Yes ☐No	**Communication issues:** ☐Yes ☐No
Indigenous status: ☐Aboriginal ☐ Torres Strait Islander ☐ Both ☐Neither		
Insurance status: ☐ Public ☐Private ☐ Health Fund:		
Patient location: eg. Hospital, Home, RACF	**Other services involved**: eg HACC	
Has patient been hospitalised outside WA in past 12 months? ☐Yes ☐ No	**Date of last hospital admission:** / /	

Diagnosis details (please ensure relevant detailed medical letters and results accompany this form and indicate any attachments below)

Primary diagnosis:		**Date of diagnosis:** / /
Reason for referral:	☐Assessment ☐Advice ☐Consultation ☐Support	☐Direct patient care ☐Assistance with discharge planning ☐Terminal phase
Attachments provided:	☐Safety alerts ☐Micro alerts ☐Pathology results ☐Discharge summary	☐Current medications list ☐Medical correspondence ☐Diagnostic imaging results ☐Other
Current issues/needs:	☐Physical symptoms ☐Psychosocial ☐Equipment ☐Mobility	☐Devices ☐Wound care ☐Oxygen ☐Other

Consent	
Is patient aware of diagnosis? ☐Yes ☐No	**Has the patient consented to referral?** ☐Yes ☐No
Is the carer/family aware of the referral? ☐Yes ☐No	**Is the GP aware of the referral?** ☐Yes ☐No
Does the patient have an Advance Health Directive? ☐Yes ☐No ☐Don't Know	
Does the patient have an Enduring Guardian? ☐Yes ☐No ☐Don't Know	
Alternative contact/Person responsible/Parent	
Name:	**Relationship to patient:**
Address:	**Post code:**
Home phone:	**Mobile:**