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.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: _____

Address: _____

_____

_____

Relationship: _____

Phone No: _____

If Main Carer and next of kin are not the same, please add comments/details to *Any other relevent 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 :

	Patient	Family / Carer
Diagnosis	Yes / No	Yes / No
Prognosis	Yes / No	Yes / No
Referral	Yes / No	Yes / No

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

Referred by:

Phone / Bleep:

Date:

Signed:

GP:

Phone:

Aware of Referral: Y / N

Consultant(s):

Hospital(s) attended:

Referral form available at http://www.hse.ie/eng/about/Who/clinical/natclinprog/pallcareprog.html