REFERRAL for EoLCSS

Head Office
2 Birdwood Avenue, Moonah 7009
PO Box 1025, Glenorchy 7010
P (03) 6208 0500 **F** (03) 6273 3002

Please fax/email to:
End of Life Care Supplementary Services
F (03) 6273 3002
E intake@thedistrictnurses.org.au

Client

Date of Referral (dd/mm/yyyy):	Client Consent:
Name:	DOB (dd/mm/yyyy):
Gender:	Phone:
Address:	
Country of Birth:	Preferred Language:

☐ CALD ☐ Aboriginal ☐ Torres Straight Islander ☐ LGBTIQA+ ☐ Interpreter Required

Primary EoL Dx:

Specify (25 Words):

Include relevant medical & social phx. Include cultural sensitivities and known death traditions/practices.

Are there any risks with visiting this home? Home Risk Assessment (if available) is attached ☐ Attached

Alerts:

Main Contact / Primary Contact

Name:	Relationship:
Phone:	Email:

Other Contact

Name:	Relationship:
Phone:	Alternative Phone:

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GP

Name:	Phone:

Lead Coordinator of Care

Name:	Organisation:
Phone:	Email:
Participants in Care:	

Current Funding sources (tick all that apply):

☐ CHSP ☐ HACC ☐ Home Care Package

☐ Carers Gateway ☐ DVA

☐ NDIS ☐ Private Self-Funding

☐ Other (please specify)

Service Referrals: ☐ HACC ☐ My Aged Care ☐ Other (please specify below:)

☐ Allied Health

Pre-emptive Medications: ☐ Yes (attach medication chart if available) ☐ No

AKPS Assessment Criteria (tick one):

☐ 90 Able to carry on normal activity, minor signs or symptoms of disease

☐ 80 Normal activity with effort, some signs or symptoms of disease

☐ 70 Care for self, unable to carry on normal activity or do active work

☐ 60 Occasional assistance but is able to care for most needs

☐ 50 Requires considerable assistance and frequent medical care

☐ 40 In bed more than 50% of the time

☐ 30 Almost completely bedfast

☐ 20 Totally bedfast & requiring nursing care by professionals and/or family

☐ 10 Comatose or barely rousable

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Living Arrangements:
Equipment in Place (tick all that apply): ☐ Hospital Bed/Mattress ☐ Commode ☐ Hoist ☐ Powerlift Chair ☐ Wheelchair ☐ Other (specify below)
Other:
Reason for Referral (tick all that apply): ☐ Personal Care ☐ Respite ☐ Overnight - Nursing Support ☐ Nursing ☐ Social Support ☐ Allied Health ☐ Overnight sits - Support Worker ☐ Other Specify particulars:
After Hours Plan:
Attached EoL Planning: (Please provide if/when available) ☐ Medical Goals of Care (required) ☐ Notification of Expected Death ☐ Advanced Care Directive (must provide documents) ☐ My Envelope
Preferred Place of Death:

Referrer Name:	Designation:
Organisation:	
Phone:	Email:
Additional Notes:	