Palliative Care Referral

Ringwood PRIVATE HOSPITAL by Healthscope

Enquiries and referrals

P 03 8804 4261 **F** 03 8804 4010 **E** ringwood.admissions@healthscope.com.au

Patient Details

First Name:	Surname:
Date of birth: / /	Gender: Male ☐ Female ☐
Address:	
	Postcode:
Country of birth:	Phone number:
Medicare number:	Does the patient have Private Health Insurance? Yes ☐ No ☐
Health insurance details:	Health insurance number:
Is the patient currently in hospital?	Yes ☐ No ☐
Has the patient given permission for this referral to be made?	Yes ☐ No ☐
Is the patient currently being cared for by a community palliative care service?	Yes ☐ No ☐
Name of the Service:	Contact number of the service:
Does the patient and family understand the diagnosis/ prognosis?	Patient ☐ Family ☐
Full name of carer/ next of kin:	Contact number of carer/ next of kin:

Referring doctor details

Doctor's first name:	Doctor's surname:
Type of referring doctor: Specialist/ General Practitioner	Provider number:
Clinic name:	Postcode:
Phone number:	
Clinic address:	
Clinical details:	
Primary diagnosis:	
If cancer, state sites of metastatic disease:	Date of diagnosis: / /
Reasons for referral:	
Symptom management ☐ End of life care ☐ Other (please describe below)	
Allergies:	

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Advance care plan

Has the patient completed an advance care plan?	Yes ☐ No ☐
Is there a nominated medical treatment decision maker?	Yes ☐ No ☐
Full name of medical treatment decision maker:	
Contact number of medical treatment decision maker:	
Full name of person completing this form:	
Phone number of person completing this form:	
Role of the person completing this form: eg. GP/ Liaison nurse	

General Practitioner (if different to referring doctor)

Full name:	Contact number:
Address:	
	Postcode:

Ringwood Private Hospital
36-38 Mt Dandenong Road, Ringwood East VIC 3135 | **P** 03 8804 4000 | **F** 03 8804 4111 | ringwoodprivatehospital.com.au
ABN 85 006 405 152