Queensland Government

Gold Coast Health

RURAL SPECIALIST PALLIATIVE CARE TELEHEALTH SERVICE

Facility: _____

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Please complete all sections of this form and fax referral to (07) 5668 6070 or email to gcruralpallcare@health.qld.gov.au

If not already determined, please also phone 1300 618 486 to arrange the details of the telehealth consult including an agreed time of the consult and details of which local clinician (e.g. GP, community nurse etc) will be present with the patient.

This form and the attached referral may be completed by any clinician but must be signed by a Doctor or Nurse Practitioner and include their provider number.

☐ Referral from: _____

☐ Address & contact details: _____

☐ Date: _____

☐ Patient name: _____

☐ Patient date of birth: _____

☐ Patient address: _____

☐ Patient phone number: _____

☐ Medicare number / expiry date: _____

☐ Next of kin name and contact details: _____

☐ Current medication and allergy list

☐ Specialist correspondence

☐ Relevant Radiology Results

☐ Relevant Laboratory Results

☐ Please attach copies of any of the following
(EPOA, AHD, ARP, Statement of choices)

Kind regards,

Rural Telehealth Palliative Care Service

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Referring GP / Consultant / Specialist: _____

Referrer contact details: _____

Community nursing service (N/A if none): _____

Community nursing service phone number: _____

Is the patient/family aware of this referral, their condition and their diagnosis? ☐ **Yes** ☐ **No**

Referral Details: (please provide a short summary the patient's diagnosis and review needs)

(Please also provide the following details as this assists triage, treatment plans and data recording processes)

PRIMARY DIAGNOSIS (principal life-limiting illness)

Estimated Prognosis: ☐ Days ☐ Weeks ☐ Months ☐ Years

Malignant:			
☐ Bone and soft tissue	☐ Gynaecological	☐ Pancreas	☐ Other GIT
☐ Breast	☐ Haematological	☐ Prostate	☐ Other Urological
☐ CNS	☐ Head and Neck	☐ Skin	☐ Other Malignancy
☐ Colorectal	☐ Lung	☐ Unknown Primary	☐ Location Metastases _____

Non-Malignant:		
☐ Cardiovascular disease	☐ Alzheimer's disease	☐ Diabetes and its complications
☐ HIV / AIDS	☐ Other dementia	☐ Sepsis
☐ End stage kidney disease	☐ Other neurological disease	☐ Multiple organ failure
☐ Stroke	☐ Respiratory failure	☐ Other non-malignancy
☐ Motor neurone disease	☐ End stage liver disease	

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Symptoms and other concerns:

☐ Pain	☐ Fatigue	☐ Dyspnoea	☐ Nausea and vomiting
☐ Constipation	☐ Family / carer support	☐ Anxiety and distress	☐ Counselling
☐ Other physical symptoms	☐ Prognostication	☐ Ceiling of care	☐ Terminal care

Specialty advice required:	☐ Medical	☐ Pharmacy	☐ Nursing
	☐ Occupational Therapy	☐ Social work	☐ Other

Ongoing Treatment plan:

Is the patient still receiving active treatments for their terminal illness (e.g. chemotherapy) ☐ Yes ☐ No

Has the management of acute deterioration been discussed ☐ Yes ☐ No

Is hospitalization and acute management appropriate if clinically indicated ☐ Yes ☐ No

Are any of the following complete?

☐ Advance Care Plan completed

☐ Enduring Power of Attorney completed

☐ Statement of Choices

Additional relevant details:

Name of Doctor / Nurse Practitioner: **Provider Number:**

Signature: **Date:**

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In terms of clinicians, who will be physically present with the patient at the planned telehealth consult?

☐ Community nurse
☐ Outpatient nurse
☐ Nursing home nurse
☐ Medical practitioner (GP or another doctor)
☐ Other clinician

Name of clinician: _____

Mobile phone number of the clinician: _____

Contact phone number of admin staff helping arrange: _____

Contact email of admin staff helping arrange: _____

What is the location of the planned telehealth consult?

☐ A residential aged care facility
☐ At home or another private residential address
☐ At a GP surgery / medical centre
☐ In an outpatient department or local hospital
☐ At another site

Land-line phone number at this site: _____

Preferred method of telehealth consult?

☐ Web-browser link / WebEx
Please advise email address of clinician: _____

☐ QH Cisco telehealth number or address – please provide number / address _____

☐ Skype – please advise Skype username: _____

☐ Microsoft Teams – please advise Queensland Health email: _____

☐ Facetime – please advise iPhone number or iCloud address: _____

Expected wireless or mobile coverage:

☐ Mobile coverage – is there mobile phone coverage at the consult site?
☐ 4G coverage – is there 4G coverage at the consult site?
☐ Broadband – is there wireless or ethernet broadband access at the consult site?

Please note are any risks or hazards to be aware of for the clinician who will be present with the patient?

Name and signature: **Date:**

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