Request for Hospice Admission

Referrals@fitzroyhospice.org.au I Ph: 07 4887 4138 I Fax: 07 49 362 725

Fitzroy Community Hospice is licensed to provide sub-acute palliative care and support for adults. Referred patients must be 18 years old or above and have;

- an advanced, progressive, life limiting condition *and* be aware of their diagnosis and prognosis;
- stopped receiving curative treatment for their primary life-limiting condition;
- agreed to not receive cardio-pulmonary resuscitation or assisted ventilation;
- consented to hospice referral;
- a body weight less than 120kg;
- an appropriate reason for admission, such as -
    - short to medium term end-of-life care i.e., last days and weeks of life care
    - short term symptom management e.g., treatment of troublesome pain, constipation, nausea (or other palliative symptoms) that would otherwise necessitate a hospital admission
    - short term carer crisis respite; and
- sub-acute care needs i.e., be medically stable and have non-complex care requirements

Patients with one or more of the following characteristics or care needs, must be discussed with the CEO-Director of Clinical Services *prior to referral* -

- a body weight of 120kg to 150kg;
- wandering with a need for constant or near-constant supervision;
- a health condition or behaviour that may pose a risk to the health and safety of other patients, staff, or persons at the facility;
- a current or anticipated need for -
    - high cost medications and/or high cost dressings
    - non-routine pathology (being pathology tests other than full blood count, liver function tests, urea and electrolytes)
    - imaging other than plain x-ray
    - intervention or treatment not provided by the Hospice e.g. blood products, intravenous chemotherapy, radiation therapy, dialysis, interventional pain management; and
- seeks admission for the sole purpose of voluntary assisted dying.

Once received by the Hospice, all referrals will be assessed by senior Hospice clinical personnel as well as the Hospice Medical Team Doctor. A Medical request to handover care must occur at this time. The referrer will be contacted to clarify or seek additional information.

Notification of the Referral Outcome will occur within 8 hours of receipt of the referral, and admission of the patient will occur within 24 hours of acceptance.

Patient Details (OR affix Patient Label)	☐ Mr	☐ Mrs	☐ Miss	☐ Ms
Family Name:				
Given Names:			Preferred Name:	
Address:				
Suburb:	Post Code:		Telephone:	
Date of Birth:	Age:		Religion:	

Marital Status:	☐ M	☐ W	☐ Div/Sep	☐ S
Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No				
Country of Birth:	Primary Language:			
Medicare Number:	Identifier:		Expiry Date:	
Current care situation: At home: □ lives alone □ Lives with Spouse/Family/Carer Hospital facility: …….. Other: ……..				

Next of Kin/Contact Person:		Relationship:	
Telephone:	EPOA: ☐ Yes ☐ No	Email:	
Usual GP:	Practice Name:		
Telephone:	Fax:	Email:	
Is a Community Nursing Service involved presently? ☐ Yes ☐ No			
Name of Service:		Telephone:	
Is the CQHHS Specialist Palliative Care service involved presently? ☐ Yes ☐ No			
Comments:			

Primary Life-Limiting Condition:
Date of Diagnosis:
Known metastatic sites (if applicable):
Previous Treatment(s) ☐ Surgery ☐ Radiotherapy ☐ Chemotherapy ☐ Other……..
Details:
Other Relevant Diagnoses/Medical Information:
Weight: _____ Oxygen dependent? □ Yes □ No has own Oxygen concentrator? □ Yes □ No
Implanted device e.g., pacemaker, intrathecal pump, spinal cord stimulator? □ Yes □ No
Reason for Referral:
☐ Short to medium term end-of-life care i.e., last days and weeks of life care
☐ Short term symptom management; primary symptom ……..
☐ Short term carer crisis respite with discharge plans in place
Current Clinical Issues and Hospice care needs:
Is the patient medically stable and has non-complex care requirements? ☐ Yes ☐ No
Does the patient wander, with a need for constant or near-constant supervision? ☐ Yes ☐ No

Does the patient have a health condition or behaviour that may pose a risk to the health and safety of other patients, staff, or persons at the hospice facility? ☐ Yes ☐ No
If Yes, details:

Patient aware of Diagnosis and Prognosis: ☐ Yes ☐ No Family Aware: ☐ Yes ☐ No

Patient agrees to not receive cardio-pulmonary resuscitation or assisted ventilation ☐ Yes ☐ No

Patient has stopped receiving curative treatment for their primary life-limiting condition ☐ Yes ☐ No

Patient consents to Hospice Referral: ☐ Yes ☐ No

Current Level of Function:

Mobility

☐ Independent
☐ Full Weight Bearing
☐ Partial Weight Bearing
☐ Rest in Bed
☐ Transfer with 1
☐ Transfer with 2
☐ Lifting Machine Transfer
☐ History of Falls

Aids

☐ Walking Stick
☐ Frame
☐ Manual Wheel Chair
☐ Powered Wheel Chair

Cognitive State

☐ Alert and Orientated
☐ Agitated
☐ Unconscious
☐ Confused

Reason / Duration:

Hygiene

☐ Independent
☐ Assist x 1
☐ Full Assist

Communication Status:

Hearing Impaired
☐ Yes ☐ No

Vision Impaired
☐ Yes ☐ No

Aids Used: ☐ Yes ☐ No
Type Used:

Diet: ☐ Normal Other (Specify)
☐ PEG Feed Regime

Continent: ☐ Yes ☐ No
Incontinent: ☐ Urinary Catheter ☐ Yes Date Inserted:
☐ Bowel Stoma ☐ Yes

Wound Management (Type and Treatment):

Known/Identified Infections:

Copy of Current Medication Chart: ☐ Yes ☐ No If No, Please Complete Below Current Medications: Known Allergies:				
Drug	Dose	Route	Frequency	Indications

Advanced Care Planning
Patient has an Advanced Health Directive: ☐ Yes ☐ No
Patient has a Statement of Choices: ☐ Yes ☐ No
Patient has an Acute Resuscitation Plan: ☐ Yes ☐ No
Patient has an Enduring Power of Attorney for Healthcare: ☐ Yes ☐ No Name: ……..
On transfer patients must have a medical transfer letter, copies of recent test results, current medications and any other relevant information.

Referrer:	Role/Title:
Is the Referrer credentialled to provide care at the Hospice and willing to admit this patient ☐ Yes ☐ No	
Referral Address:	Contact Number(s):