Children's Health Ireland at Crumlin

# CHI Palliative Care Referral Form

Full Name: .....
Address: Addressograph
.....
HCR.....

| **Referring Consultant:** | **Receiving Consultant:** |
|---|---|
| **PATIENT IS CURRENTLY:** At home ☐ | An inpatient ☐ |
| **Date of Admission:** | **Ward:** |

## URGENCY OF REFERRAL

2 Working Days or under ☐ **Must be accompanied by phone contact from Referrer**

One Week ☐ One Month ☐

## REASON FOR REFERRAL *(please tick appropriate reason)*

| | | | |
|---|---|---|---|
| Symptoms Management | | Emotional or Psychosocial Support | |
| End of Life Planning | | Ethical Decision Making | |
| Rapid Discharge for End of Life / Palliative Care | | Other | |

## PATIENT DETAILS

| Name: | Date of Birth: *Age:* | Gender: *Male* ☐ *Female* ☐ |
|---|---|---|
| Patient Address: | | |
| Interpreter Required: Yes ☐ No ☐ | Language: | |

Patient aware of Palliative Care Referral: Yes ☐ No ☐ N/A ☐

## NEXT OF KIN DETAILS

| *Parent / Legal Guardian 1* | *Parent / Legal Guardian 2* |
|---|---|
| Name: | Name: |
| Relationship to child: | Relationship to child: |
| Address: | Address: |
| Home Phone No: | Home Phone No: |
| Mobile No: | Mobile No: |
| *Parents / Guardians aware of Palliative Care Referral:* *Yes* ☐ *No* ☐ | |

## GP

| Name: | Phone: | Fax: |
|---|---|---|
| Address: | | |

## CURRENT DIAGNOSIS

*Diagnosis, treatment to date, further treatment planned (e.g. recent admission(s), radiotherapy, chemotherapy etc.)*

**Doctors Name**:..... **Registration No**:.....**Date**:.....