Government of South Australia
SA Health

Metropolitan Referral Unit - Palliative Referral Form

Referral Fax: 1300 546 104 Email: Health.MRU@sa.gov.au

Referral source ☐ Public hospital ☐ GP ☐ Palliative Care Service ☐ Other

PATIENT INFO Sticker/MR10/UR No: .....

Surname: ..... First name: .....

Address: .....

Suburb: ..... P/Code: .....

☐ Male ☐ Female DOB: ..... / ..... / .....

Telephone: .....

Mobile: .....

Address where care to be provided (if not usual address)

Address: .....

Suburb: .....

Date of referral: ..... / ..... / ..... Time: .....

Requested Service Commencement date: ..... / ..... / .....

Referring Hospital/ Agency: .....

Ward/Unit: ..... Ext No: .....

Admission date: ..... / ..... / ..... Discharge date: ..... / ..... / .....

Aged Care Facility: ☐ Low level ☐ High Level

USUAL LIVING:

☐ Alone ☐ With Family ☐ With Spouse/Partner

☐ Homeless ☐ Friend/s ☐ Other: .....

NOK: ..... (Relationship): ..... GP/Practice: .....

NOK Phone(s): ..... GP Phone: .....

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: ..... Interpreter required? *specify* .....

DVA Card Holder ☐ Yes ☐ No (DVA number) ..... Health Fund ☐ Yes ☐ No

KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment/ Animals /Aggression)

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PRIMARY DIAGNOSIS (including date of surgery if applicable): .....

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PMH & Secondary Conditions: .....

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ALLERGIES: ..... MRO: ☐ MRSA ☐ VRE ☐ Other MRO *(specify)*: .....

Prognosis is the patient in the last weeks of life? ☐ Weeks ☐ Months ☐ Not Known

PHASE: ..... AKPS: ..... RUG–ADL : ..... *(if known)*

PATIENT INFO Sticker/MR10/UR No: .....

Surname: ..... First name: ..... Suburb: ..... P/Code: .....

Address: ..... ☐ Male ☐ Female DOB: ..... / ..... / .....

COMMUNITY SERVICES & New referrals (including MAC referral and reference number)	**Current/New**	Details – contact name & phone number	Referred Date

MANAGEMENT PLAN to include current symptoms and care required:

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MOBILITY: .....

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Existing equipment in the home: .....

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ATTACHED (if applicable): ☐ Medication Authority ☐ Discharge Summary ☐ Wound Chart ☐ Resuscitation Plan – 7 Step Pathway

Referrer's signature:	Print Name: .....
.....	Role/Designation: ..... Contact number: .....

Please complete form and send via email Health.MRU@sa.gov.au or FAX to 1300 546 104.
Access and download forms and resources: www.sahealth.sa.gov.au/MRU or Phone 1300 110 600.