

Rural & Remote Palliative Care Telehealth Service

(Affix identification label h	nere)
URN:	
Family name:	
Given name(s):	
Address:	
Date of hirth:	v.

RURAL & REMOTE PALLIATIVE CARE TELEHEALTH SERVICE

Please complete all sections of this referral and submit via:

Fax: (07) 5687 2119 or

Referral Details:

Email: GCsparta@health.qld.gov.au

If not already determined, please 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 referral may be completed by any clinician but must be signed by a Doctor or Nurse Practitioner and include their provider number.

Referrer Name:
Address & contact details:
Date://
Patient Details:
Patient name:
Date of birth:
Address:
Phone number:
Medicare number: expiry date: // // //
Next of Kin name and contact details:
GP Name and Practice Name:
Treating Practitioner (if different from GP):
Please include the following with this referral:
☐ Current medication and allergy list



Specialist correspondence

□ Relevant Radiology Results

Relevant Pathology Results

Please attach copies of any of the following: EPOA, AHD, ARP, Statement of Choices

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	(Affix identific	ation label here)
Queensland Government	URN:	
Carros A. Hello	Family name:	
Rural & Remote Palliative	Given name(s):	
Care Telehealth Service	Address:	
Facility:	Date of birth:	Sex: M F I
Referral Details: (please provide a short summa	ry the patient's diagnosis and rev	view needs)
Is the patient / carer / family aware of this referral,	the patient's condition and their d	liagnosis? Yes No
Community Nursing Service (N/A if none):		
Community Nursing Service Phone Number:		
Please provide the following details, as this assis	ts triage, treatment plans and da	ta recording processes:
Primary Diagnosis (principle life-limiting illne	ss)	
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 of Metastases:
Non-Malignant:		

│ Alzheimer's disease	│ │ HIV / AIDS	⊢⊟Strok

- е
- ☐ Cardiovascular disease ☐ Motor neurone disease \square Other dementia
- $\hfill\Box$ Diabetes and its complications ☐ Multiple organ failure ☐ Other neurological disease
- $\hfill\Box$ End stage kidney disease $\hfill\square$ Respiratory failure $\hfill\Box$ Other non-malignancy
- $\hfill\Box$ End stage liver disease ☐ Sepsis

Queensland Government	
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Given name(s):					
Address:					
Date of birth:		Sex:	M	F	

Rural & Remote Palliative Care Telehealth Service		Family nar	ne:				
		Given nan	ne(s):				
		Address:					
Facility:		Date of bir	th:	Sex:	М	F	
Symptoms and other conce							
☐ Anxiety and distress	Dyspnoea		☐ Pain				
☐ Ceiling of care	☐ Family / carer s	upport	☐ Prognostica	ation			
☐ Constipation	☐ Fatigue		☐ Terminal ca				
☐ Counselling	☐ Nausea and vor	miting		ical symptoms			
Specialty advice required:							
Medical	Dharmacy		Nursing				
Occupational Therapy	☐ Pharmacy☐ Social Work		☐ Nursing				
Occupational Merapy	Social Work		U Other.				
Ongoing treatment plan:							
Is the patient still receiving act	tive treatments for th	eir termir	al illness (e.g. che	motherapy)?	□ Y	es [☐ No
Has the management of acute	deterioration been	discussed	1?		□ Y	es [No
Is hospitalisation and acute ma	anagement appropri	ate if clini	cally indicated?		□ Y	es [No
Are any of the following con	nnleted?						
Advance Care Plan	iipiotou :						
☐ Enduring Power of Attorney	V						
Statement of Choices	,						
Additional relevant details:							
Additional followant dotailor							
Name:		De	esignation:				
Signature:		Da	ite:				

	Queensland
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URN:					
Family name:					
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Address:					
Date of birth:		Sex:	\square M	□ F	

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Rural & Remote Palliative	Family name:				
Care Telehealth Service	Given name(s):				
	Address:				
Facility:	Date of birth:	Sex:	\square M	F	
Telehealth Consult Details					
Which clinician will be physically present with	the patient at the planned teleheal	th co	nsult?		
Community nurse					
Outpatient nurse					
☐ Nursing home nurse					
☐ Medical practitioner (GP or another doctor)					
Other clinician:					
Name of Clinician:					
Clinician's mobile phone number:					
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 (RACF)					
☐ 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:					
QH Cisco telehealth number or address. Dial-in det	ails:				
(*Please note: Gold Coast have a CMR number that ca	n be utilised)				
☐ Web-browser link:					
Please advise email address of clinician:					
Skype – advise Skype username:					
☐ Microsoft Teams – advise Queensland Health email					
☐ Facetime – advise iPhone number or iCloud address	s:				
Expected wireless or mobile coverage:					
☐ Mobile coverage – is there mobile phone coverage a	at the consult site?				
\square 4G coverage – is there 4G coverage at the consult s	site?				
☐ Broadband – is there wireless or ethernet broadband	d access at the consult site?				
Address: Date of birth: Sex: M F D Dehealth Consult Details Dehealth Consult Details Dehealth Consult Details Dehealth Consult Details Dehealth Consult Department with the patient at the planned telehealth consult? Dommunity nurse Dutpatient nurse Dehealth Consult dehealth consult Dehealth Consults Dehealth Con					