LODDON MALLEE QUICK REFERENCE GUIDE
APPRORIATE REFERRAL TO SPECIALIST PALLIATIVE CARE SERVICE

loddon mallee
regional palliative care consortium
Enhancing life and quality of health

Section 1

Consider referral to a Specialist Palliative Care Service if ticked "Yes" to the following:

	The person has a diagnosed terminal illness (malignant or non-malignant)
	The person is not receiving curative treatment for the illness (may be receiving treatment for symptom management or resolution)

Additional consideration for referral if ticked for any of the following:

Patient Wellbeing	
	Uncontrolled, or Complex pain (can be more than one site/type)
	Other uncontrolled or rapidly changing symptoms (e.g. nausea; anxiety, breathlessness)
	Recent diagnosis
	Metastatic malignancies
	Recurrent or locally extensive disease
	Deterioration of non-malignant conditions
	Relapse, resistant or refractory disease
	Has no carer
	Other: _____
Carer Wellbeing	
	Has a carer who is also a carer for someone else
	Grief is interfering with physical and/or emotional functioning
	Other: _____

If not appropriate for referral to Palliative Care, consider referral to other support services as identified with patient and carer. Proceed to section 2 for palliative care

Section 2

Before referring to the Specialist Palliative Care Service, tick when the following are completed:

	Needs Assessment completed (use the NAT:PC http://www.newcastle.edu.au/research-centre/cherp/can-meet-needs-resource/ , or similar tool)
	The person lives within the service area
	The person/family or carer(s) are aware of the referral

On Referral to the Specialist Palliative Care Service, include:

M	Consumer Information* (name, address, phone no, GP, NOK, carer, MDS items)
M	Palliative Care Supplementary Information* (3 pages)
M	Summary and Referral* (include phase of illness**, avoid duplication of info on PCSI)
	Copy of completed Needs Assessment, or summary (Description of Issues* section)
	Additional Profiles* or Supplementary Templates*
	Other relevant documents / assessments

* Preferred referral document is the Service Coordination Tool Template. SCTTs can be downloaded from http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm

** see Phase Definitions on reverse

M = Mandatory requirement

This guide has been developed from the LM "Timely Specialist Palliative Care Assessment and Support" document, and Palliaitve Care Referral triage Form, Echuca Regional Health.
Phase of Illness Definitions from the Palliative Care Outcomes Collaborative (PCOC) data definitions.

Phase Definitions

The palliative care phase is the stage of the patient's illness. Palliative care phases are not sequential and a patient may move back and forth between phases.

Palliative care phases provide a clinical indication of the level of care required and have been shown to correlate strongly with survival within longitudinal, prospective studies. Phases are defined in terms of the following criteria as these highlight the essential issues to be considered when assigning phase.

Stable (All clients not classified as unstable, deteriorating or terminal)

- The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned
- The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care

Unstable

- The person experiences the development of a **new unexpected problem or a rapid increase** in the severity of existing problems, either of which requires an **urgent** change in management or emergency treatment
- The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team

Deteriorating

- The person experiences a **gradual worsening** of existing symptoms or the development of **new but expected problems.** These require the application of specific plans of care and regular review but **not urgent or emergency treatment**
- The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary

Terminal

- Death is likely in a matter of days, and no acute intervention is planned or required. The typical features of a person in this phase may include the following:
    - Profoundly weak
    - Essentially bed bound
    - Drowsy for extended periods
    - Disoriented for time and has a severely limited attention span
    - Increasingly disinterested in food and drink
    - Finding it difficult to swallow medication
- Frequent, usually daily, interventions aimed at physical, emotional and spiritual issues
- The family/carers recognise that death is imminent and care is focused on emotional and spiritual issues as a prelude to bereavement