PALLIATIVE CARE REFERRAL FORM

(Clinics and Consultations) **COVID EMERGENCY**

[Name of doctor and service]

Email: ……………………… Fax: ……………..…. Tel: ……………..……

Mr/Mrs/Ms……………………...………………………………………

Place of birth…………………… Date of birth……………………….............

Address ………………………………………District ……………….………

Admitted to (name of hospital)…………..……………………….............

Ward ……………………………………Date of admission………………........

Comorbidity: Cardiovascular ☐; Diabetes ☐; Respiratory ☐; Cancer ☐
Clinical issues: Dyspnoea at rest and/or when speaking ☐;
Respiratory rate > 22 breaths/min ☐; PaO2 < 65 mmHg or SpO2 < 90% ☐;
Radiological evidence of worsening ☐; Pain ☐; Agitation ☐
Organ failure or dysfunction ☐; Deterioration in laboratory tests ☐;
Ongoing drug treatment: Antiviral ☐; Immunosuppressive ☐;
Monoclonal antibody ☐; Chloroquine ☐; Morphine ☐
Specify dose:…………………………………………………………………
Life support measures: Respiratory: NIV ☐; Invasive ventilation ☐;
Haemodynamic support ☐; Renal support ☐
The patient: Can communicate independently ☐; Is aware about his/her condition and/or has asked to be kept personally informed ☐; Has asked for relatives to be informed about his/her clinical condition ☐
Other:…………………………………………………………………………

Name, surname and phone number (must provide MOBILE PHONE number) and relationship of relative to be informed of referral:

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☐ WARD CONSULTATION ☐ MEETING WITH FAMILY

Please forward clinical details to: Fax: ………………..Email :**...........@...........**

Referring professional (physician or nurse):

Dr. …..…………………………………………………………………….............

(legible signature and stamp)

Tel.……………………………….………..… Mobile phone..……………………….………

Email: ……………………………………… Date of referral……/…/…………