Western Health

Renal Supportive Care Referral Form

Date:

Please email referral form to RenalSupportiveCareCNC@wh.org.au

Patient name: ..... **UR:** .....

Date of Birth: ..... **Medicare No:** .....

Contact details: **(Home)** **(Mobile)**

Special needs ☐ Mobility ☐ Other **Interpreter required:** ☐ No ☐ Yes

Primary Nephrologist If yes, specify:

Reason(s) for referral (tick all that apply)

☐ Education for Conservative Care

☐ Advanced Care Planning

Person who wishes to undertake ACP conversations +/-

Advance Care Directive completion

☐ Symptom management (please highlight: dialysis / non-dialysis)

☐ Palliative approach integration

☐ GP and community services support and link to Renal services

Additional information

Would I be surprised if this person died within the next 12 months?

☐ Yes ☐ No

☐	100	Normal; no complaints; no evidence of disease
☐	90	Able to carry on normal activity; minor sign of symptoms of disease
☐	80	Normal activity with effort; some signs or symptoms of disease
☐	70	Cares for self; unable to carry on normal activity or to do active work
☐	60	Able to care for most needs; but requires occasional assistance
☐	50	Considerable assistance and frequent medical care required
☐	40	In bed more than 50% of the time
☐	30	Almost completely bedfast
☐	20	Totally bedfast and requiring extensive nursing care by professionals and /or family
☐	10	Comatose or barely rousable
☐	0	Dead

☐ IPOS-Renal

Past Medical History

Please provide any further relevant information (ie. symptoms list, previous ACP discussions)

Referral from

Name: .....

Position: .....

Tel: ..... **Email:** .....