(this project is funded under the National Palliative Care Program and is supported by the Australian Government Department of Health and Ageing)

Tasmania
GENERAL PRACTICE
north west

TRANSFER TO HOSPITAL CHECKLIST

PALLIATIVE CARE/COMMUNITY NURSING CLIENT

Palliative Care/Community Nursing Service to complete

Client Details (sticker if available)
URN DoB
Name
Address
Phone

Clients carer/Next of Kin		
Name:	Relationship:	Ph:
Name:	Relationship:	Ph:
Name:	Relationship:	Ph:

This client receives			
Palliative Care Service	☐	Contact:	Ph:
Community Nursing Service	☐	Contact:	Ph:
Home Help	☐	Contact:	Ph:
Personal Care	☐	Contact:	Ph:
Hospice	☐	Contact:	Ph:
Social Work	☐	Contact:	Ph:
Other	☐	Contact:	Ph:

Doctors/Specialists involved in care	
General Practitioner:	Ph:
Palliative Care Specialist:	Ph:
Other:	Ph:
Other:	Ph:

Reason for Transfer:
Notes:

Enclosures/Notifications			
Nursing assessment	☐	Enduring Guardianship	☐
Current drug chart	☐	NFR	☐
Advance Care Plan	☐	GP Notified of DEM presentation	☐
		DEM Notified of expected presentation	☐

Please retain this envelope with the clients' notes; upon discharge the envelope should accompany the client home

DISCHARGE FROM HOSPITAL CHECKLIST

PALLIATIVE CARE/COMMUNITY NURSING CLIENT

RMO & Nursing staff to complete

Client Details (sticker if available)
URN DoB
Name
Address
Phone

Discharge details

Discharge from NWRH ☐ MCH ☐		Other facility:
Discussed with Community Nursing	☐	Name:
Discussed with Palliative Care Service	☐	Name:
Discussed with General Practitioner	☐	Name:

Discharge Summary Letter (including diagnosis)

Original enclosed	☐	
Faxed/Emailed to Community Nursing	☐	
Faxed/Emailed to Palliative Care Service	☐	
Referral form Faxed/Emailed	☐	Sent to:

Medication

Copy of drug chart enclosed	☐	
Medication supply given to client	☐	Days supplied:
CSCI (syringe driver)	☐	Due for change: / / : am/pm
Script provided to client	☐	Script sent to NWRH pharmacy ☐
Script sent to private pharmacy	☐	Pharmacy:

Notes:

Appointments

Appointment with GP	Date:	Time:
Appointment with Specialist	Date:	Time:
Other:	Date:	Time:

Form completed by: Date: