ADVANCE CARE PLANNING REFERRAL

Northern Health

Patient Details: *(* indicates fields that must be completed for referral to be accepted)*	**Referrer Details:**
Name *_____ UR _____ DOB *: __/__/__ Address _____ _____ Sex: ❑ Male ❑ Female ❑ Other Phone *_____ Interpreter required? ❑ No ❑ Yes If yes specify language _____	Person making referral *_____ Contact *_____ Email *_____ **Consent:** Has the patient provided consent for ACP team involvement? ❑ No ❑ Yes*
Previously Completed Forms: (*tick all that apply)*	**Service Requested ***
❑ Appointment of Medical Treatment Decision Maker or MEPOA ❑ Appointment of Support Person? ❑ Advance Care Directive? ❑ Other: _____	❑ Discussion about Advance Care Planning ❑ Assistance appointing a Medical Treatment Decision Maker ❑ Assistance completing Advance Care Directive ❑ Assistance appointing Support Person OR ❑ Advice for MTDM regarding person who lacks capacity to complete an Advance Care Directive
Reason for Referral:	
❑ Patient request ❑ Multiple hospital admissions ❑ Life-limiting illness ❑ Conflict in decision-making ❑ Has difficulty communicating but may be able to make decisions with support	
Other Considerations:	
Please email referrals to acp@nh.org.au or Phone: 9495 3235 Forms and guides available for download from: www.nh.org.au/service/advance-care-planning	
Name: _____ Designation: _____	Signature: _____ Date: __/__/__ Time: __:__