Bethesda health care

Monday to Friday 8am – 4pm

Email: MPaCCS@bethesda.org.au
Phone: 9217 1777
Fax: 9217 1788

Referral Forms:
www.bethesda.org.au/mpaccs

Metropolitan Palliative Care Consultancy Service (MPaCCS)
REFERRAL FORM

Resident's Full Name			
Resident's Date of Birth		Gender	☐ M ☐ F
Resident's Facility			
Facility Phone			
Facility Location	☐ North ☐ South ☐ East		

Referral Date		Referrer Name	
GP Name		Referrer Position	
Primary life limiting illness (malignant or non malignant)		Referrer	☐ RACF Staff Member ☐ GP ☐ Hospital (please state)..... ☐ RCL ☐ CoHive ☐ WAVED ☐ Other (please state).....
GP supports MPaCCS involvement	☐ Yes ☐ No	Person/family aware of this referral	☐ Yes ☐ No
Main Referral Reason	☐ Symptom Management Advice ☐ Advance Care Planning Support ☐ Staff Support ☐ Terminal Care Support ☐ GP Requested Referral		
Other Referral Reasons and Relevant History (please provide relevant details ie why are you referring this person to our service?)	Karnofsky score: (see over for info)		
Key Issues or Needs (use '++' for most severe or distressing)	☐ Physical Symptoms ☐ Emotional Distress ☐ Spiritual or Existential Distress ☐ Communications or Conflict ☐ Other:		
Documents Attached (please attach, if available)	☐ Recent Discharge Summary ☐ Current Advance Care Plan/s ☐ Current Medications List ☐ Other:		

Referral Priority Indicators

Referral Priority	Please circle which best applies to this referral, below

Within 1 – 2 Days ☐	Within 5 Days ☐	More Than 5 Days ☐
▪ The person is in the terminal phase (ie days to live), or ▪ The person is in the unstable phase (ie rapid clinical deterioration, unmanaged symptoms) & urgent specialist input is required	▪ The person is approaching the terminal phase (ie a month or weeks to live), or ▪ The person is in the deteriorating phase (ie gradual clinical deterioration), and ▪ specialist input is needed to plan for possible likely needs or support communications	▪ The person is in the stable phase (ie existing care plan meets needs), and ▪ Assessment is needed to identify possible future needs, and ▪ (Advance) care planning is required to meet possible future needs

MPaCCS is not a 'rapid response' service. Where a review is required urgently, please call the service to discuss.

- MPaCCS assists facilities & GPs with specialist medical & psychosocial assessment, care planning & case review for residents approaching the end-of-life. Residents receiving life-prolonging treatment are not excluded from palliative care referral.
- MPaCCS is a capacity building service and does not admit patients who are not receiving direct 24 hour care from health professionals.
- Referrals are accepted from doctors, nurses or allied health providers.
- The GP retains clinical responsibility.
- MPaCCS is managed by Bethesda Healthcare and funded by the WA Department of Health.

AKPS: Australia-modified Karnofsky Performance Status			
100	Normal; no complaints; no evidence of disease	40	In bed more than 50% of time
90	Able to carry on normal activity; minor signs or symptoms	30	Almost completely bedfast
80	Normal activity with effort; some signs of symptoms of disease	20	Totally bedfast & requiring extensive nursing care by professionals &/or family
70	Cares for self, but unable to carry on normal activity or to do active work	10	Comatose or barely rousable
60	Requires occasional assistance, but can care for most needs	00	Dead
50	Requires considerable assistance & frequent medical/nursing care	*Consider 'terminal phase' if AKPS is ≤ 20/100, & there has been recent significant functional decline.*	

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems. The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vasoular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; best available treatment has a poor outcome.

Review current care and care planning.

- Review current treatment and medication to make sure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family/people close to them. Support carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, share, and review care plans.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™ 2022