



# Nurse Practitioner Scope of Practice

## Palliative Care

Name:

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***A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise. Nurse Practitioners (NP) work collaboratively as an interdependent member of the multidisciplinary health care team. NPs provide autonomous, patient centred care. Direct patient care is central to the NP role (ANMC 2006) (1).***

***This document reflects what is currently regarded as best practice for the specialty of Palliative Care. As in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.***

***The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the NP in light of the clinical data presented by the patient and the diagnostic and treatment options available. In making clinical decisions the NP should remain conscious of their level of expertise and take advantage of the expertise of all members of the treating team.***

***The authorising legislation for Nurse Practitioner prescribing, possession, supply & use of poisons, restricted substances and drugs of addiction is the Poisons & Therapeutic Goods Act 1966 (2) & Poisons and Therapeutic Goods Regulation 2008 (3).***

***The relevant legislation regarding Nurse Practitioners is the Health Practitioner Regulation National Law (NSW) No 86a (4).***

***Practice will be in accordance with current best evidence and all relevant NSW Health and SAH policies, procedures and guidelines.***

***This Practice Scope of the Nurse Practitioner complies with NSW Health Policy Directive Nurse/Midwife Practitioners NSW PD 2005\_556, 21-March -2005 (5) .***

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## 1.0 Palliative Care Nurse Practitioner Scope of Practice

### 1.1 Introduction

The scope of practice of an individual nurse practitioner is influenced by the settings in which they practice; the health needs of the client; the level of competence of the nurse and the policy requirements of the service provider (1, 6).

The Nurse Practitioner practices at an advanced level, providing autonomous and collaborative expert palliative care nursing for patients with a life limiting illness. This includes promotion and maintenance of optimum health, as well as the provision of individualised palliative care. Working autonomously and collaboratively with a range of multidisciplinary and interdisciplinary primary, secondary and tertiary services, the Nurse Practitioner responds to actual and potential health needs using advanced nursing knowledge, expertise and evidence to improve health outcomes for patients and families with complex palliative care needs.

The Scope of Practice forms part of the Safety and Quality Framework (SQF) (7) which outlines the professional governance framework within which all NP's must comply.

The Palliative Care Nurse Practitioner (PCNP) is a unique role, so it is anticipated that the scope of practice will evolve as the role expands. Flexibility in the role design should allow for future directions which will occur within the health service and the community.

### 1.2 Definitions

A Nurse Practitioner (NP) is a Registered Nurse/Midwife with advanced knowledge, complex decision making skills and recognised clinical competence for expanded practice, the characteristics of which are shaped by the context in which s/he is educated and competent to practice and whom the Australian Health Practitioner Regulation Agency (APHRA) has endorsed as a Nurse Practitioner.

'A Nurse Practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The NP role is grounded in the nursing professions values, knowledge, theories and practice and provides innovative and flexible health care delivery that compliments other health care providers.' (1).

The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with living with a life limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychological and spiritual" (8).

The PCNP is recognised as an advanced practice nurse with additional qualifications, experience, skills and knowledge within the speciality of palliative care. The core business of the PCNP is to appropriately assess and autonomously and collaboratively manage patients with symptoms associated with life limiting illness.

## 2.0 Demographics

### 2.1 Northern Sydney Local Health District (NSLHD)

The Northern Sydney Local Health District extends from the Hornsby LGA in the North West to Ryde LGA in the south. NSLHD comprises 5 local government areas (LGAs). The SAH's service provision is not limited by Local Health Districts and covers approximately 6 LGA's, with most patients attending from suburbs within a 10 – 15 Km radius from SAH, an estimated area of 707 square kilometres. This area includes many aged care facilities.

Breakdowns of percentages are as follows:

10 km radius - 72.5%

15 km radius - 13.1%

Outside of Region - 14.6%

Population in this area is estimated at approximately 759,893. With an aging population an increase in demand of palliative care services is expected.

### 2.2 SAH Palliative Care Key Performance Indicators 2010

Total Number of Patients	359
Total Number of Deaths in Hospital	189
Transferred to other Hospitals	19
Transferred Home	140
Transferred to ACF	11

### 2.3 Services within the SAH include but are not limited to:

- Emergency Care Department
- General Surgery
- Orthopaedics and Vascular Surgery
- General Medicine
- Cardiology
- Intensive Care and Coronary Care
- Occupational Therapy and Physiotherapy Services
- Acute Pain Service
- Social Worker and Spiritual Care Services
- Pathology and Radiology Services
- Paediatric and Special Care Nursery
- Oncology and Radiotherapy Services
- Palliative care
- Chronic and Complex care

## **3.0 Context of Practice - Palliative Care Nurse Practitioner (PCNP)**

### **3.1 Background**

Sydney Adventist Hospital currently provides inpatient palliative care services. This majority of patients are seen within the hospital with a very small proportion of acute palliative care patients being cared for at home by Hospital in the Home (HITH). Currently community services and Residential Aged Care Facilities are serviced by public sector personnel. In principle the Palliative Care Team meet the requirements of a Specialist Palliative Care Level 1 Service. The Palliative Care Nurse Practitioner (PCNP) is an integral part of the palliative care service whose aim is to provide timely access to clinical expertise for patients and their carers in the unstable, deteriorating and terminal phases of their illness.

### **3.2 Age Range of Patients**

The age range of patients will be eighteen years and over.

### **3.3 Presenting Conditions and Disease States**

Palliative Care refers to the care of patients with a life limiting illness. Often these patients may be referred early in their illness trajectory for symptom control or psychosocial issues. Once the issues are resolved the patient is discharged until they require the service again.

Life limiting illness includes but is not restricted to end stage:

Malignancy; neurodegenerative disorders; dementia; renal disease; cardiovascular disease; chronic respiratory disease and AIDS related diseases. These disease processes can manifest a multitude of complex symptoms for patients.

The PCNP will not see patients with chronic pain only.

### **3.4 Practice Environment**

The PCNP covers the geographical area of the upper north shore of Sydney. The primary practice environment for the PCNP is Sydney Adventist Hospital. Additionally, there is a consultation service for local aged care facilities within a ten kilometre radius of SAH.

### **3.5 Model of Care**

The model of care for the PCNP will evolve over time and will adhere to the following foundations and principles:

- to be an extension of the existing Palliative Care services;
- to be part of a multidisciplinary team;
- to foster collaborative relationships with other service providers;
- to provide an innovative and flexible nursing service that improve patient outcomes;
- to promote timely access to care and support;
- to work within the Scope of Practice according to principles of best practice;
- to provide advanced nursing care, management and evaluation;
- to work across boundaries of care provision;
- to promote the quality of life of patients and their families;
- to provide care that is holistic and encompasses the physical, psychological and spiritual.

## 4.0 Process of Care

### 4.1 Referral

#### 4.1.2 Reason for Referral

Generally patients are referred to the PCNP for the following reasons:

- Management of patients with complex symptoms who have needs exceeding the scope of the palliative care team;
- Exacerbation of symptoms, sudden change or deterioration in condition;
- End of life care in the terminal phase of the illness

#### 4.1.3 Criteria for Referral

Life limiting illness includes but is not restricted to end stage:

malignancy; neurodegenerative disorders; dementia; renal disease; cardiovascular disease; chronic respiratory disease and AIDS related diseases. These disease processes can manifest a multitude of complex symptoms for patients.

Patients may be referred early in their illness trajectory for management of symptoms and then discharged when symptoms have resolved.

The age range of patients will be eighteen years and over.

#### 4.1.4 Source of Referral

Health Care Professionals SAH  
Residential Aged Care Facilities  
SAH Emergency Care Department (for follow up on discharge from EC)  
SAH Case Managers  
NUM POON  
NUM HITH  
NUM SDIC  
Cancer Support Centre  
Carers, families, patients

#### 4.1.5 Referral Pathway

All referrals are made using the PCNP referral form (to be designed) faxed to Level 6 POON ward (02 9487 9650). Referrals are then triaged and prioritised according to the Palliative Care Priority Intake Tool (Appendix 1).

Referrals will be accepted by telephone – providing follow-up documentation is provided.

### 4.2 Assessment and Management

The assessment and management of individuals by the PCNP is aimed at managing symptoms, determining where the patient is in their illness trajectory and determining reversible and irreversible conditions. The process is guided by evidenced based practice.

This process includes a comprehensive holistic assessment of the patient and their family / carer(s) and an advanced physical examination as appropriate. SAH is currently investigating the implementation of the Palliative Care Outcomes Collaboration (PCOC) (14).

#### **4.2.1 Diagnosis**

Following assessment and examination the PCNP establishes a provisional diagnosis and analyses the information gathered to determine symptoms with potentially reversible pathophysiology and where the patient is in their illness trajectory.

#### **4.2.2 Investigation**

Investigations are required to assist diagnosis or provide a baseline of health. The PCNP may order appropriate medical imaging and pathology investigations if there will be a clear benefit to symptom management and patient outcome. Appropriate investigations may include but are not limited to:

- Urine culture and sensitivity
- Sputum culture and sensitivity
- Wound swabs culture and sensitivity
- Pathology: including FBC; Group & hold cross match; LFT; Calcium (corrected); UEC; INR; APPT.
- Medical Imaging: Plain X-rays – including chest, abdomen, skeletal
- Other diagnostic investigations may be ordered following discussion with the medical team.

It is the responsibility of the PCNP to ensure that these results are followed up, interpreted and documented in a timely manner and to consult appropriately with the medical team to discuss management or referral if required.

If the PCNP is away on leave arrangements will be made for the follow up of any investigations ordered.

The PCNP has a commitment to prevent duplication of services and unnecessary diagnostic investigations and consultation with pathology and medical imaging staff should occur as appropriate.

#### **4.2.3 Development of a Management Plan**

The management plan for the patient is developed according to the following:

- The patients and families wishes for treatment and place of care;
- Where the patient is in their illness trajectory;
- The agreed management plan from the Medical Specialist;
- Discussion around Advance Care Planning;
- Decisions made in partnership with the patient, family, General Practitioner and Medical Specialist;
- Collaboration with and referral to other health professionals as required.

#### 4.2.4 Prescribing Medications

- The PCNP formulary lists the poisons and restricted substances that may be processed, used, supplied or prescribed by the nurse practitioner under Section 17a of the Poisons and Therapeutic Goods Act 1966 (2) & Part 1 section 4 & 4A of the Poisons Therapeutic Goods Regulation 2008 (3).
- The PCNP is allocated a Prescriber Number and may prescribe items included on the PBS schedule as NP items for patients who are not discharged inpatients, outpatients or emergency patients in a NSW public hospital setting.
- The PCNP can prescribe medications on an inpatient medication chart. The PCNP can also prescribe PBS subsidised medication for community patients.
- The PCNP has the authority to initiate, cease and titrate those medications listed in the PCNP Formulary.
- Medications will only be prescribed following assessment of the individual patient.
- The principles of the Quality Use of Medicines are observed (15).
- The PCNP will use the most recent Australian Medicines Handbook (16); MIMS or MIMS 'online' (17); and Therapeutic Guidelines: Palliative Care (18).
- The PCNP will document, maintain and update medical records for all medication changes made by the PCNP. The PCNP will observe, record, report patient's condition, efficacy and reaction to drugs and treatment to the relevant health professionals.
- The PCNP will consult with the GP / Medical Specialist / Palliative Care Specialist, when appropriate, to discuss management plans for complex patients and for those patients not responding as expected to recommendations.
- Many medications used in Palliative Care are used 'off label', for indications, and routes of administration outside of the TGA approval. These indications and routes of administration are evidenced based in the Palliative Care literature.
- The PCNP can cease drugs no longer required after discussion with the patient and family and at the request of the General Practitioner or Medical Specialist.
- Patients in the terminal phase of their illness will have reduced ability or inability to swallow medications. The PCNP will reduce or cease oral medications and change to an alternate route as appropriate. This process is undertaken in an informative collaborative manner with the patient, family and carer's.
- The PCNP will document, maintain and update medical records for all medication changes made by the PCNP. The PCNP will observe, record, report patient's condition, efficacy and reaction to drugs and treatment to the relevant health professionals.

#### 4.2.5 Evaluation and Follow Up

- The PCNP will re-evaluate and reassess the patient and their family as required following the implementation of a management plan.
- The PCNP will ensure that appropriate referrals to other services have been acted on.
- Referral to the Palliative Care specialist for the provision of ongoing monitoring.
- The PCNP can be consulted again as required.
- The PCNP will promote the quality of life of patients and their families during the course of the life limiting illness and into the bereavement period – including appropriate and timely referral to bereavement services.

## 5.0 Clinical Practice

### 5.1 Clinical Practice Guidelines

The clinical practice of the PCNP will be guided by acknowledged sources of evidence based practice:

Therapeutic Guidelines: Palliative Care Version 3 2010 (19) <http://proxy9.use.hcn.com.au/>

Therapeutic Guidelines: Analgesic Version 5 2007 (20) <http://proxy9.use.hcn.com.au/>

Therapeutic Guidelines: Psychotropic Version 6 2008 (21) <http://proxy9.use.hcn.com.au/>

Therapeutic Guidelines: Antibiotics Version (22) <http://proxy9.use.hcn.com.au/>

eviQ (23) <https://www.eviq.org.au/Category/tabid/65/categoryid/552/Default.aspx>

eviQ Opioid Calculator (24) <https://www.eviq.org.au/OpioidCalculator.aspx>

Caresearch (25) <http://www.caresearch.com.au/caresearch/tabid/65/Default.aspx>

Doran, J. (2006) (26) Palliative Care Pain Management Guidelines  
[http://int.ncahs.nsw.gov.au/documents/storage/clinical\\_guideline/CLP-AREA-Palliative\\_Care\\_Pain\\_Management-V-003.pdf](http://int.ncahs.nsw.gov.au/documents/storage/clinical_guideline/CLP-AREA-Palliative_Care_Pain_Management-V-003.pdf)

Talley, N.J., and O'Connor, S. (2010) Clinical Examination: a systematic guide to diagnosis 6<sup>th</sup> Edition; Churchill Livingstone Elsevier, Sydney (27)

Eastern Metropolitan Region Palliative Care Consortium Victoria (2008) Syringe Driver Medication Compatibilities – Practice Guidelines (28)  
<http://www.emrpcc.org.au/Uploadlibrary/400287568EMRPCCSyringeDriverMedicationGuidetoPracticeFINALOctober2008.pdf>

### 5.2 Collaborative Arrangements

Collaborative arrangements are required to enable Nurse Practitioners to provide access for patients to MBS and PBS subsidy. Arrangements are in line with s5(1a) of the National Health (collaborative arrangements for nurse practitioners) Determination 2010.

### 5.3 Practice Limitations

According to the patient's phase, where the patient is in their illness trajectory and the agreed management plan for the patient the PCNP will consult appropriately:

- Persistent signs or symptoms beyond the expected time of resolution despite treatment;
- Sign(s) of recurrent or persistent infection;
- Any atypical presentation of a common illness or unusual response to treatment;
- Any sign(s) or symptom(s) of behavioural changes that cannot be attributed to a specific organic cause;
- Palliative Care emergencies such as cord compression, hypercalcaemia, superior vena cava obstruction;

- Symptomatic or laboratory evidence of previously unidentified change in condition or unexpected deteriorating function of any vital organ or system;
- When a patient's condition destabilises unexpectedly;
- When it is determined by the PCNP after assessment, be it ongoing or emergency, that the treatment or diagnostic test needs fall outside the approved Scope of Practice;
- When a patient requires admission;
- Any other conditions or patients who are outside the approved Scope of Practice.

A therapeutic management plan will be formulated by the PCNP in line with best practice. Consent will be obtained from patients prior to consultation and Scope of Practice and Drug Formulary will be made available to other health professionals within multidisciplinary team.

## 6.0 Outcome Measures

### 6.1 Desired outcomes of interventions by the PCNP include:

- Advanced, comprehensive & holistic health assessment relevant to Palliative Care patients and their families; both within the inpatient and outpatient setting.
- Identification of “high risk discharges” and implementing a “Fast Track” admission to inpatient care bypassing the need to be assessed in Emergency Care as appropriate.
- The ability to work across services, in collaboration with community teams already involved with patient care, manage symptoms in the community setting promoting seamless and continuous care
- Management of symptoms in an outpatient setting as appropriate with the aim of minimising hospital admissions.
- Continuity of clinical care across the community / inpatient / Residential Aged Care continuum, including direct liaison with other specialist teams including primary medical and nursing care providers;
- Provision of appropriate and timely treatment / interventions in the terminal and pre-terminal phases to manage pain and other symptoms;
- Advanced clinical expertise in the assessment and referral of bereaved carers to palliative care multidisciplinary teams and other health professionals to facilitate ongoing management where appropriate;
- Education and support to the patient and their carers;
- Facilitation of timely access to appropriate interventions, multidisciplinary services and equipment;
- Identification, prevention & management of any adverse event;
- Communication and collaboration with the multidisciplinary team;
- Utilisation of evidence based practice

### 6.2 Outcome Indicators

The following indicators will be monitored by the PCNP:

- Utilisation of PCNP in the pre-terminal phases;
- Utilisation of PCNP to assess and facilitate appropriate bereavement care for family and carers;
- Utilisation of PCNP for palliative care symptom control;
- Collection of PCOC data (still being determined);

- Evaluation of data that include reason for referral and outcomes;
- Participation in SAH quality activities.

## 7.0 Clinical Governance

- The PCNP is responsible operationally to the Director Patient Flow responsible for (Cancer Service Development (Nursing))
- Clinically responsible to the Palliative Care Specialist
- Professionally responsible to the Nursing Executive Officer, Sydney Adventist Hospital

## 8.0 Accountability

The PCNP is accountable for their clinical practice decisions and actions, together with their conduct as a health professional. The Safety & Quality Framework (5) that maps the PCNP's domain of responsibility and accountability includes the following:

- The PCNP Scope of Practice;
- The Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner (1);
- Mandatory Reporting;
- The ANMC Code of Ethics and Professional Conduct for Nurses in Australia (29, 30);
- The NSW Health Code of Conduct (PD2005\_626) (31);
- Annual Declaration;
- Co-regulatory requirements of Medicare and NMBA;
- NMBA Audit Process;
- Prescribing Authority legislation and collaborative arrangements;
- Notification of performance, conduct or health matters.

In addition, the PCNP will comply with all applicable SAH and NSW Health policies, procedures and guidelines.

The PCNP is responsible for the maintenance of their clinical knowledge and skills through ongoing professional development.

In an emergency situation the PCNP will be expected to do no harm, and to act in the best interests of the patient.

The PCNP will participate in the continuing evaluation of the Palliative Care service.

## 9.0 Professional Practice

To facilitate the delivery of care, the PCNP will operate with due regard to relevant National, State and Local Health District documents including:

- National Palliative Care Strategy 2010: Supporting Australians to Live Well at the End of Life (32)
- Standards for Providing Quality Palliative Care for all Australians (12)
- Role Delineation Framework for Palliative Care 2007 (33)
- Palliative Care Strategic Framework 2010-2013 (34)

The PCNP uses appropriate language and assessment techniques according to National, State and Local Health District Policies; Local hospital protocols and procedures; the Australian Nursing and

Midwifery Council Competency Standards for the Nurse Practitioner (1) and Nursing and Midwifery Board of Australia regulations.

The PCNP meets regularly as a part of the multidisciplinary team on Level 6 POON Ward.

The PCNP receives Clinical Supervision from Pastoral care team.

The PCNP also meets regularly with other Nurse Practitioners from NSW and ACT.

## 10.0 Education, Clinical Leadership and Research

The PCNP role is primarily a direct clinical role (80%) and encompasses Clinical Leadership as part of an advanced practice role. Education, quality and research are also aspects of the role. Indirect clinical activities (20%) include:

- The provision of advice and guidance for nurses on matters of clinical practice and professional development;
- The provision of expert advice, education and support to nursing staff and other health professionals in a variety of settings including Residential Aged Care, Hospital, Community and Tertiary environments;
- Participation in the review and evaluation of policies, procedures and guidelines to improve standards of patient care in relation to Palliative Care;
- Participation in formal processes for the strategic and operational planning for the Palliative Care service;
- Demonstrated leadership with regard to the ANMC Professional Code of Conduct and Code of Ethics for Nurses.
- Ensuring that all standards, policies and procedural recommendations of the organisation, the nursing professional bodies and national and state professional palliative care bodies are maintained;
- Working to advance the understanding and integration of the Nurse Practitioner role in the Health Service and community.
- Involvement in research activities and initiation of research activities.

## 11.0 Amendment

The PCNP and Nursing Council shall update and amend the scope of practice whenever the PCNP's duties have substantively changed or every twelve months when the service requirements are reviewed, incorporating the annual performance appraisal.

Any alterations must be submitted to the Chief Executive of Sydney Adventist Hospital. This document is invalid if any alterations or amendments are made without the approval from the Chief Executive of Sydney Adventist Hospital.

## 12.0 Acknowledgements

This Scope of Practice has been developed and adapted with the support of the following people who have generously shared their Scopes of Practice, Formularies, expertise and time:

Judith Jacques – Palliative Care Nurse Practitioner - CCLHD;  
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Debbie White – Palliative Care Nurse Practitioner MNCLHD;  
Pauline Wilson – Palliative Care Nurse Practitioner SWCN.

### 13.0 Scope of Practice Document

A small working group was established to assist in the development of the PCNP Scope of Practice. Once the draft document has passed through executive it will be sent for sign off by the Chief Operating Officer and staff listed on the sign off sheet.

#### Acknowledgements:

Moran Wasson, Nursing Executive Officer SAH  
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Anne Temblett, Director Patient Flow responsible for (Cancer Services Development (nursing) SAH

In consultation with:

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Dr Jeanette Conley, Director Medical Services SAH  
Steve Cargo, Director Pharmacy SAH  
Niki Farahani, Pharmacist SAH  
Brigitte Karle, Nursing Unit Manager POON Ward SAH  
Ross Penman, Director Medical/ Surgical Nursing

### 14.0 Approval and Sign Off

<b>Approved By:</b>	<b>Name</b>	<b>Signature</b>	<b>Date:</b>
Nursing Council Chairperson	Moran Wasson		
Pharmacy and Drug Committee Chairperson	Dr Jeanette Conley		
Medical Advisory Committee Chairperson	Dr L Giutronich		
Palliative Care Specialist	Dr Gillian Rothwell		
Executive Committee Chairperson	Dr Leon Clark		

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Appendix 1

Name:	DOB:
Referral From: Hospital <input type="checkbox"/> Outpt Dept <input type="checkbox"/> GP <input type="checkbox"/> Self/Family <input type="checkbox"/> Other: <input type="checkbox"/>	
Inpatient: SAH <input type="checkbox"/> DalcrossEDD: <input type="checkbox"/>	
Reason for Referral:	
Discussed with: Referrer <input type="checkbox"/> GP <input type="checkbox"/> Patient <input type="checkbox"/> Carer <input type="checkbox"/> Other: <input type="checkbox"/>	
Main Issues:	
1.	
2.	
3.	
4.	
Phase: Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Terminal <input type="checkbox"/>	
AKPS: 100 90 80 70 60 50 40 30 20 10 0	
RUG ADL: 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	
Overall Problem Severity Score: Absent <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
Other services involved:	
Meets referral criteria: Yes <input type="checkbox"/> No <input type="checkbox"/> ->Action: NSP <input type="checkbox"/> Clinical Advice Given <input type="checkbox"/> Referral <input type="checkbox"/> see below	
If no, could existing services be increased? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Referral to:	
Shared care:	
Equipment:	
Priority Outcome: Urgent – within 2 days <input type="checkbox"/> Moderate Urgency 3-7 days <input type="checkbox"/> Non-urgent 7-14 days <input type="checkbox"/>	
GP Health Summary Requested <input type="checkbox"/> Discharge Summary <input type="checkbox"/> MOSAIQ <input type="checkbox"/>	
PCOC Registration(awaiting approval) <input type="checkbox"/> Medical Record Requested <input type="checkbox"/>	
Initial Contact:	Date for Admission:
Comments/Plan:	
Intake Nurse Signature:	Date:

