NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

ACCELERATED TRANSFER TO DIE AT HOME PARAMEDIC TRANSFER LETTER

Date: _____/_____/_____

Mr / Mrs / Ms: _____ is being transported to the below address for the purposes of facilitating their wish to die at home. Therefore, the focus is solely on comfort care. **CPR should not be attempted in the event of cardiopulmonary arrest.**

Destination address: _____

_____

Contact person at destination

Name: _____

Phone number: _____

In the event that care at home is no longer possible the goals of care remain as documented even if place of care changes.

The patient has a subcutaneous infusion in place ☐ Yes ☐ No

Time and medication given prior to transfer home:

Time: _____:_____

Medication/s: _____

_____

In the event of the patient dying while being transported home/to the RACF by ambulance, you should:

- Follow the NSW Health Resuscitation Plan (Adult).
  Completed copy attached: ☐ Yes ☐ No
- Follow the NSW Ambulance Authorised Palliative Care Plan (Adult) accompanying patient (if available).

Further information you may require: _____

_____

_____

_____

Yours sincerely,

Doctor / senior nurse's name: _____ Signature: _____

Designation: _____ Contact number: _____

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PARAMEDIC TRANSFER LETTER
SMR010.062