HPC Teams for Central LHIN
A Partnership for Caring

Stronach Regional Cancer Centre
596 Davis Drive
Newmarket, ON L3Y 2P9

Tel: 905-895-4521, ext. 6388
Email: HPCTeams@Southlakeregional.org
Website: www.centralhpcnetwork.ca/hpc/hpcteams.html

LONG TERM CARE REFERRAL FORM TO HPC TEAMS **FAX TO: 905-830-5978**

Date of Referral: (dd/mm/yyyy) ___/___/___ **Urgency:** ☐ 1-2 days ☐ within 1 week ☐ 1-2 weeks

Resident Name: (First) _____ (Last) _____

DOB: (dd/mm/yyyy) ___/___/___ Gender: ☐ Female ☐ Male

Health Card #: _____ Version Code: _____

Long Term Care Home: _____

Address: _____ Room #: _____

City: _____ Postal Code: _____

Phone #: _____

Date of Admission to Nursing Home: _____

Primary Contact Person Name/Relationship: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

REASON FOR REFERRAL: ☐ Pain and Symptom Management Consultation

☐ Other - please specify: _____

Is DNR Signed: Yes ☐ No ☐ Goals of Care: _____

PRIMARY DIAGNOSIS: _____

Cancer Metastases *(check all that are known):* ☐ Bone ☐ Brain ☐ Liver ☐ Lung

☐ Other (specify): _____

Psychosocial History: _____

Current Medications: _____

PRESENTING SYMPTOMS (ESAS Scores): (*rate symptoms: 0=no symptom, 10=worst symptom)*

Pain: ____/10 Tiredness: ____/10 Nausea: ____/10 Depression: ____/10 SOB: ____/10

Anxiety: ____/10 Drowsiness: ____/10 Appetite: ____/10 Wellbeing: ____/10 Other: ____/10

Palliative Performance Scale (PPS) ☐ **10%** ☐ **20%** ☐ **30%** ☐ **40%** ☐ **50%** ☐ **60%** ☐ **70%** ☐ **80%** ☐ **90%** ☐ **100%**

REFERRAL SOURCE:

Referring Name: _____ Signature: _____

Date: (dd/mm/yyyy) ___/___/___ Phone #: _____ Fax #: _____

Form completed by: _____ Phone #: _____

PLEASE ATTACH: ☐ Recent Consultation Notes ☐ Current Medications ☐ Other Relevant Information

AD-HPC-28

HPC Teams for Central LHIN
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596 Davis Drive, Box 22
Newmarket, ON L3Y 2P9

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Email: HPCTeams@Southlakeregional.org
Website: www.centralhpcnetwork.ca/hpc/hpcteams.html

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

FAX TO: 905-830-5978

I hereby authorize _____
Name of Person/Agency

_____
Address *Telephone*

To release to **Hospice Palliative Care Teams for Central LHIN**
Name of Person/Agency

Stronach Regional Cancer Centre, 596 Davis Drive, Box 22, Newmarket, ON L3Y 2P9
Address *Telephone*

Relating to _____
Name of Client *Date of Birth*

_____
Health Card Number *Telephone*

Relevant Confidential Information, specifically,

1. _____
2. _____
3. _____

To be used for the following specific purpose(s):

1. _____
Must be clearly stated
2. _____

Signature: _____ _____
Please Print Name

Relationship to Client:

❑ Self ❑ Parent ❑ Guardian ❑ Power of Attorney * ❑ Substitute Decision Maker
❑ Legally Appointed Designate*
❑ Other (please specify) _____

*If you are the Power of Attorney or Legally Appointed Designate, please provide a copy of the document to support your status.

Signature of Witness: _____ _____
Please Print Name

Date (dd/mm/yyyy): _____

This release expires 90 (ninety) days from date signed.

A Partnership for Caring:
Central CCAC, Southlake Regional Health Centre &Temmy Latner Centre for Palliative Care