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

# REFERRAL FORM

**FAX TO: 905-830-5978**

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

**Patient Name:** (First) _____ (Last) _____

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

Health Card #: _____ Version Code: _____

**Patient Address:** _____ Apt/Unit #: _____

City: _____ Postal Code: _____

Home Phone #: _____ Alternate Phone #: _____

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

Primary Care Physician Name: _____ Phone #: _____

Is a Home Visiting Physician assigned? ☐Yes Dr:_____ Phone #: _____
☐No

**REASON FOR REFERRAL:** ☐ Pain and Symptom Management Consultation ☐ Referral to Palliative Physician
☐ Other - please specify: _____

**DIAGNOSIS:** _____

**Cancer (Primary Site):** _____

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

Psychosocial: _____

**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%**

Patient receiving CCAC services ☐ Yes ☐ No Case Manager Name: _____

Nursing Agency: _____ Nurse Name: _____

**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

**CS-HPC-07**

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

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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**