

Palliative Care Common Referral Form

TO ALL PALLIATIVE CARE PROVIDERS
(For the purpose of this form, an individual refers to a patient or client)

Your submission of this form will be taken to explicitly mean that you have gained appropriate permission for release of the information contained to the agencies and services to whom you are submitting this. Please also include your Organization's Release of Information Form, if applicable.

Please complete this form as thoroughly as possible and PRINT clearly. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section.

Name: _____
(Individual's Last Name, First Name)

Goals of Care/Reason for Referral:

- Application Checklist** (include if available):
- Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)
 - Communication to the individual's family physician of referral for palliative care services
 - Copy of completed Do Not Resuscitate Confirmation Form
 - Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) Recent Chest X-Ray
 - Infection control management (e.g. MRSA/VRE/C-DIFF, etc.)
- As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.
- Recent Consultation Notes Recent Laboratory Results Pathology Reports
- Note:** Referral source must be responsible to send referral to all services requested as indicated above; if urgent response is required within 1-2 days, a phone contact must be made from the service requested.

Type(s) of Services Requested	Urgency of Response	Pages Required
<input type="checkbox"/> Community Palliative Care Physician (Specify Palliative Physician Team): _____ Referral is for: <input type="checkbox"/> Consultative Care <input type="checkbox"/> Primary Care	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks	Page 1 to 3
<input type="checkbox"/> Day Program <input type="checkbox"/> Home Visiting <input type="checkbox"/> Hospice Program	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Inpatient Palliative Care Unit (List all units referred):	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Home and Community Care Support Services Central (Complete Home and Community Care Support Services Medical Referral Form)	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks	
<input type="checkbox"/> Residential Hospice Fax to Home and Community Care Support Services Central at: • 416-222-6517 or 905-952-2404 Select Hospice Choice(s) Below: <input type="checkbox"/> Hill House (Richmond Hill, ON) <input type="checkbox"/> Margaret Bahen (Newmarket, ON) <input type="checkbox"/> Matthews House (Alliston, ON) <input type="checkbox"/> Matthews House Caregiver Relief Program (Alliston, ON) <input type="checkbox"/> Hospice Vaughan (Vaughan, ON) <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks <input type="checkbox"/> Future For Hospice Use Only: Hospice: _____ Admission Date: _____ (dd-mmm-yyyy)	
<input type="checkbox"/> Other Service(s): _____	<input type="checkbox"/> 1 to 2 Days <input type="checkbox"/> 1 to 2 Weeks <input type="checkbox"/> Future	

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PATIENT INFORMATION

Name: _____
(Individual's Last Name, First Name)

Home Address: _____
(Street No., Street Name, Building) (Apt/Suite#) (Entry Code)

City: _____ Postal Code: _____

Lives Alone Young Children in the Home Smoking in the Home Pet(s) in the Home (Specify): _____

Home Phone Number: _____ Alternate Number: _____
Date of Birth: _____ Gender: Male Female Faith/Religion: _____
(dd-mmm-yyyy)

Health Card Number: _____ Version Code: _____ Translator Name: _____
Primary Language(s): _____ Phone: _____

Current Location: Home Residential Hospice Other (Specify Address): _____

Hospital: _____ Anticipated Hospital Discharge Date: _____
(Name of Hospital) (dd-mmm-yyyy)

Primary Palliative Diagnosis: _____ Date of Diagnosis: _____
(dd-mmm-yyyy)

Other Relevant Diagnosis/Symptoms: _____

If Cancer Diagnosis - Metastatic Spread: Yes No Describe: _____

If Cancer Diagnosis - Ongoing Treatment: Yes No Describe: _____

Individual Aware of: Diagnosis: Yes No Prognosis: Yes No Does Not Wish to Know: Yes No

Family are aware of: Diagnosis: Yes No Prognosis: Yes No Does Not Wish to Know: Yes No

If family is not aware, individual has given consent to inform family of: Diagnosis: Yes No Prognosis: Yes No

Anticipated Prognosis: Less than 1 month Less than 3 months Less than 6 months Less than 12 months Uncertain

Determined By *(Name and Phone Number)*: _____

Functional Status: Palliative Performance Scale (PPS) - Refer FAQs for more details

PPS: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Resuscitation Status: Do Not Resuscitate Yes No Unknown

Discussed With: Individual Yes No Family Yes No

Family/Informal Caregivers: Provide Power of Attorney for Personal Care *(if known)*: _____

Name	Relationship	Home Phone	Business/Cell Phone

Please List All Providers and Services Currently Involved *(if known)*: Additional List Attached

Name	Phone	Fax
Family Physician		
Home and Community Care Support Services		
Community Nursing		
Hospice		
Other		

Co-Morbidities: Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

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Name: _____
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Infection Control: MRSA/VRE (+) C-DIFF (+) Other (Specify Precaution): _____

Allergies: Yes No Unknown If Yes (Please Specify): _____

Pharmacy (Name and Phone) – if known: _____

Current Medications: Medication List Attached
(Include Complementary Alternative Medications and Over-the-Counter Medications)

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Details of Social Situation, Including Any Needs/Concerns of the Family:

Special Care Needs: *(Please Check All that Apply)*

Transfusion Hydration: _____ Subcutaneous or Intravenous Infusion Pump(s) Total Parenteral Nutrition

Enteral Feeds Dialysis Central Line(s) P.I.C.C. Line(s) PortaCath Tracheostomy

Oxygen – Rate: _____ Thoracentesis Paracentesis Drains/Catheter (Specify): _____

Wound Care (Specify): _____

Therapeutic Surface (Specify): _____

Other Needs: _____

Symptom Assessment:
ESAS Score at the Time of Referral: *(Adapted from Edmonton Symptom Assessment System – ESAS, Capital Health, Edmonton)*

(Rate Symptoms: 0 = No Symptom, 10 = Worst Symptom Possible – See FAQs for Details)

Pain:	Tiredness:	Nausea:	Depression:	Drowsiness:	Appetite:
Well-Being:	Shortness of Breath:	Anxiety:	Other:		

Date ESAS Completed: _____ Insurance Information: _____
(dd-mmm-yyyy)

Has Expressed Willingness to Pay for Private Services: Yes No Unknown

For Inpatient Palliative Care Units: Private Accommodation Requested

Any Additional Information:

Form Completed By:	Phone:	Fax:
Professional Designation :		
(Referring) Physician:	Phone:	Fax:
Date of Referral: _____ <i>(dd-mmm-yyyy)</i>		