



Individual's First & Last Name:

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.

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 urgency request is within 1-2 days, a phone contact must be made to the service request

Table with 3 columns: Type(s) of services requested, Urgency of response, Pages Required. Rows include Community Care Access Centre, Community Palliative Care Physician, Hospice Program, Inpatient Palliative Care Unit, and Other.

Home Address: _____ Apt: _____ Entry Code: _____ Postal Code: _____

Please send directly to your desired hospice palliative care provider(s). Do not send to the Central Hospice Palliative Care Network.

The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered.

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

Home phone number: _____ **Alternate number:** _____

Date of birth: (DD/MM/YY) _____ **Gender:** _____ **Faith/Religion:** _____

Health card number: _____ **Version code:** _____

Primary language(s): _____ **Translator:** (name/phone #): _____

Current location: Home Residential hospice Other (specify address): _____
 Hospital Anticipated hospital discharge date: _____

Primary palliative diagnosis: _____ **Date of Diagnosis** _____

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: < 1 month < 3 months < 6 months < 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:		
CCAC		
Community Nursing		
Hospice		
Other		

Co-Morbidities: Check here if documentation is attached

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Year	Diagnosis	Year	Diagnosis

Infection Control: MRSA/VRE (+) C-DIFF (+) Other (*specify precaution*): _____

Allergies: Yes No Unknown If Yes (please specify): _____

Pharmacy (name and number) 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:

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Special care needs: (please check all that apply)

- Transfusion Hydration: SC or IV Infusion pump(s) Total Parental 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 _____ Other: _____

Date ESAS completed: _____

Insurance Information: _____

Has expressed willingness to pay for private services: Yes No Not Known

For inpatient palliative care units: Private accommodation requested

Any additional information:

Individual Completing Form: _____ **Tel:** _____ **Fax:** _____
(Referring) Physician: _____ **Tel:** _____ **Fax:** _____

Date of Referral: (DD/MM/YY) _____