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>
<thead>
<tr>
<th>Type(s) of services requested</th>
<th>Urgency of response</th>
<th>Pages Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Community Care Access Centre (complete CCAC Medical Referral Form):</td>
<td>☐ 1-2 days ☐ 1-2 weeks</td>
<td>Page 1-4</td>
</tr>
<tr>
<td>☐ Community Palliative Care Physician (Specify Palliative Physician Team):</td>
<td>☐ 1-2 days ☐ 1-2 weeks</td>
<td>Page 1-3</td>
</tr>
<tr>
<td>Referral is for: ☐ Consultative care ☐ Primary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Hospice Program: ☐ Home Visiting ☐ Day Program ☐ Residential Hospice (specify):</td>
<td>☐ 1-2 days ☐ 1-2 weeks ☐ Future</td>
<td>Page 1-4</td>
</tr>
<tr>
<td>☐ Inpatient Palliative Care Unit (List all units referred):</td>
<td>☐ 1-2 days ☐ 1-2 weeks ☐ Future</td>
<td>Page 1-4</td>
</tr>
<tr>
<td>☐ Other (specify):</td>
<td>☐ 1-2 days ☐ 1-2 weeks ☐ Future</td>
<td>Page 1-4</td>
</tr>
</tbody>
</table>

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.

1 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.

Last Modified November 2010
Palliative Care Common Referral Form | Central Hospice Palliative Care Network

- 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: _________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Business/Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list all Providers and Services currently involved: (if Known)  
- Additional list attached

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Physician:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Co-Morbidities:  
- Check here if documentation is attached

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

Last Modified November 2010
<table>
<thead>
<tr>
<th>Year</th>
<th>Diagnosis</th>
<th>Year</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Interval</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Details of social situation, including any needs/concerns of the family:**

---

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

Last Modified November 2010
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):

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Drowsiness</td>
<td></td>
</tr>
<tr>
<td>Appetite</td>
<td></td>
</tr>
<tr>
<td>Well-being</td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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:
(Referring) Physician:
Date of Referral: (DD/MM/YY)