Central Hospice Palliative Care Network

Palliative Care Common Referral Form (PC-CRF)

Frequently Asked Questions

The Palliative Care Common Referral Form (PC-CRF) has been in use by palliative care organizations across the City of Toronto since 2004. The PC-CRF was originally developed by the Toronto In-Patient Palliative Care subcommittee of the Toronto Palliative Care Network (now known as the Toronto Central Palliative Care Network) in order to standardize the application process to access palliative care services throughout the city.

In November 2010 the Palliative Care Common Referral Form was revised to a shorter, more comprehensive version. The form is a multiuse form for referral to a number of hospice palliative care resources across the Greater Toronto Area and endorsed by the Toronto Central LHIN, Central LHIN, Central East LHIN, Central West LHIN, and Mississauga-Halton LHIN. We hope that the following information will be helpful to you and your colleagues as you continue to provide support to palliative individuals and their families.

Note: The term "individual" is used to represent the "patient" or "client" who requires palliative care. The term "family" is as defined by the individual.

Q: Why a Palliative Care Common Referral Form (PC-CRF) for palliative care?

A: The PC-CRF is a communication tool. It simplifies communication and captures detailed information so that the individual does not have to remember and repeat their history or story again and again. For this reason, it is in the best interest of the individual requiring palliative care.

The PC-CRF also fosters quality communication among multiple care providers involved with the individual and family. The PC-CRF provides a baseline of information to new providers who may be involved in the care. Multiple referrals can also be made using this one form.

Q: Can I use my own referral form to refer for palliative care services?

A: The PC-CRF has been endorsed for use across the GTA including the Central LHIN Hospice Palliative Care Network . The purpose of the PC-CRF is to support the use of common language for effective communication between service providers and across care settings to ensure that all relevant information is shared in a comprehensive manner

Q: What "relevant information" is to be included?

A: Only the most current and updated information is relevant. This includes any consultative notes, results of tests and imaging, and other reports dated within the last 2 weeks, and current at time of referral (see the checklist).

Q **: Are all sections in the PC-CRF mandatory?**

A: **No**, however, completing all sections of the PC-CRF as thoroughly as possible assists palliative services to initiate care and palliative support for the individual and family with the most comprehensive information available. Where indicated medical consultations notes and medication lists can be attached for ease of completion.

Q: Does the individual have to be informed that a referral is being made for palliative care services?

A: ***Yes***. An explicit consent is required, by law, for the capable individual or substitute decision-maker. The capable individual or substitute decision-maker must be aware of the reason for referral unless he/she has expressed an explicit wish not to be informed.

Q: Who can complete the PC-CRF?

A: Any provider can initiate a palliative referral by completing the PC-CRF and act as the point of contact for the referred palliative service.

Q: Does the PC-CRF have to be completed and signed by a physician?

A: ***No***. The information obtained for the form may be from the interdisciplinary team however, the referral source should ideally be one person who knows the individual well. The individual's family physician should be notified that referrals for palliative care services are being made.

Q: Can more than one person complete the form?

A: The PC-CRF is divided into various sections. The referral source must take ownership to ensure that the form is complete. Pertinent information is missed if the form is "pulled apart". The most efficient and time-saving method is to have all information available and accessible to the referral source through patient care rounds, team rounds, etc.

Q: Why do you need to know who communicated the prognosis to the patient?

A: To facilitate follow-up if it becomes clear that the patient had additional related questions or did not understand the discussion.

Q: What do each of the services mean in "Types of Services Requested"?

A: The following is an explanation of the services (see page 1 of the PC-CRF) which the individual may require.

Community Care Access Centre: Previously known as the Home Care Program, the CCAC provides support services in the individual's home. Services include nursing, personal support, and assessments or follow up from allied health services such as dietitian, social work, occupational therapy, physiotherapy, etc. Pages 1-4 are required for all CCAC referrals *** a CCAC Medical Referral Form is required for CCAC services
Community Palliative Care Physician: Physicians in the community who provide palliative care expertise. ***medical notes, tests results are mandatory ❑ **Consultative care**: request for consultation and support for the family physician, who continues to care for the individual ❑ **Primary care**: request for the community palliative care physician to assume the role of the most responsible physician for the individual

Hospice Program: Hospice support includes care coordination, integrative wellness, bereavement support, spiritual support, volunteer support Pages 1-4 are required for all hospice referrals ❑ **Home visiting**: care provided in the home ❑ **Day Program**: time-limited activities provided at the hospice ❑ **Residential Hospice**: end of life care provided within the residential hospice **Specify the Hospice program to which the individual will be referred.
Inpatient Palliative Care Unit: Individuals who require admission to an inpatient setting with dedicated beds for palliative care provision. Admission criteria may vary. **Specify the Palliative Care Unit(s) to which the individual will be referred. Pages 1- 4 are required for all PCU referrals
Other: examples - HPC nurse consultants; Palliative care clinics, APNs, NPs

Q: If a PC-CRF was completed before and I want to refer to another service do I have to complete another form??

A: **No**, a PC-CRF update form is available as a separate document which can be completed with new or updated information and attached to the original PC-CRF when referring to another service or when updating the information.

Q: Can I put my own agency's logo at the top?

A: The form was created with a generic format to allow for individual Hospice Palliative Care Network logos to be added at the top. To support the recognition of the form, it is preferable that only Network logos be used. If your organization must insert its own logo, it may do so by requesting a word version of the form from your Hospice Palliative Care Network. To ensure that the benefits of a common referral from are not lost, the form must not be changed. All organizations that request a word version of the form are reminded of the disclaimer on the PC-CRF.

Q: What does resuscitation refer to?

A: Definition of Cardiopulmonary Resuscitation (CPR) by Ministry of Health and Long-Term Care (MOHLTC) - is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardio-respiratory arrest. These measures include basic cardiac life support involving chest compressions, and/or artificial ventilation e.g. mouth-to-mouth resuscitation, bagging, and where available, defibrillation, intubation and other procedures considered to be Advanced Cardiac Life Support procedures by the Heart and Stroke Foundation of Ontario.

Q: What is Palliative Performance Scale (PPS)?

A: Refer to the Ontario Cancer Symptom Management Collaborative: Palliative Care Tools: **http://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=76967**

Q: What is ESAS (Edmonton Symptom Assessment System)?

A: Refer to the Ontario Cancer Symptom Management Collaborative: Symptom Management Tools: **http://www.cancercare.on.ca/cms/one.aspx?portalId=1377&pageId=58189**