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
☐ **Community Palliative Care Physician** *(Specify Palliative Physician Team):* _____ Referral is for: ☐ Consultative Care ☐ Primary Care	☐ 1 to 2 Days ☐ 1 to 2 Weeks	**Page 1 to 3**
☐ **Day Program** ☐ **Home Visiting** ☐ **Hospice Program**	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ Future	
☐ **Inpatient Palliative Care Unit** *(List all units referred):*	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ Future	
☐ **Home and Community Care Support Services Central** *(Complete Home and Community Care Support Services Medical Referral Form)*	☐ 1 to 2 Days ☐ 1 to 2 Weeks	
☐ **Residential Hospice** Fax to Home and Community Care Support Services Central at: • 416-222-6517 or 905-952-2404 Select Hospice Choice(s) Below: ☐ Hill House (Richmond Hill, ON) ☐ Margaret Bahen (Newmarket, ON) ☐ Matthews House (Alliston, ON) ☐ Matthews House Caregiver Relief Program (Alliston, ON) ☐ Hospice Vaughan (Vaughan, ON) ☐ Other (Specify):	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ Future **For Hospice Use Only:** Hospice: Admission Date: _____ *(dd-mmm-yyyy)*	
☐ **Other Service(s):**	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ 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: _____ *(dd-mmm-yyyy)* **Gender:** ☐ Male ☐ Female **Faith/Religion:**

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

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: _____
(dd-mmm-yyyy)

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