

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.

Applicant: _____

(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.

Type(s) of Services Requested	Urgency of Response	Pages Required
<input type="checkbox"/> Community Care Access Centre (Complete CCAC Medical Referral Form):	<input type="checkbox"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks	Page 1-4
<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"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks <input type="checkbox"/> Future	Page 1-3
<input type="checkbox"/> Hospice Program <input type="checkbox"/> Home Visiting <input type="checkbox"/> Day Program <input type="checkbox"/> Residential Hospice (specify):	<input type="checkbox"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks <input type="checkbox"/> Future <input type="checkbox"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks <input type="checkbox"/> Future	Page 1-4
<input type="checkbox"/> Inpatient Palliative Care Unit (List all units referred):	<input type="checkbox"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks <input type="checkbox"/> Future	Page 1-4
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> 1-2 Days <input type="checkbox"/> 1-2 Weeks <input type="checkbox"/> Future	Page 1-4

- Please send directly to your desired hospice palliative care provider(s)
- **For application to Matthews House Hospice** please fax to the Central CCAC at Fax (416) 222-6517 or Fax (905) 952-2404

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Applicant: _____
(Last Name, First Name)

Home Address (Street. No./St. Name/Bldg.) _____ **Apt/Suite#** _____ **Entry Code** _____

City _____ **Postal Code** _____ **Telephone**
 (Home): _____
 (Other): _____

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

Date of Birth: _____ **Gender:** Male Female **Faith/Religion:** _____
(dd-mmm-yyyy)

Health Card Number: _____ **Version Code:** _____

Primary Language: _____ **Translator:** _____
Other Languages: _____ Name: _____
 Tel: _____

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: < 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

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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.

Year	Diagnosis	Year	Diagnosis

Infection Control:

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

Allergies:

Yes No Unknown If Yes (please specify): _____

Pharmacy (Name & Tel. No.) 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 _____
Drowsiness _____
Nausea _____
Lack of Appetite _____

Shortness of Breath _____
Depression _____
Anxiety _____
Well-being _____
Other _____

Date ESAS

Completed: _____
(dd-mmm-yyyy)

Insurance

Information: _____

Applicant/Family has expressed willingness to pay for private services:

Yes No Not Known

For inpatient palliative care units: Private accommodation requested

Any Additional Information:

Applicant Completing Form: _____

Signature

Tel: _____

Fax: _____

(Referring) Physician: _____

Signature

Tel: _____

Fax: _____

Date of Referral: _____

(dd-mmm-yyyy)

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