Palliative Care Hospice & In-Patient Referral

Date of Application:		Date of Admission:	

Personal Information				
Last Name		First Name		
Date of Birth		Age		Male Female
Address		Apt# City	Prov.	Postal Code
Home Telephone		Present Location (home, hospital, LTC, ED)		
Family Physician	Phone Fax	Most Responsible Physician	Phone Fax	
Health Insurance Information				
Is patient covered under Ontario Health Insurance Plan? No Yes Last name on health card _____		Health Insurance Number		Version Code
Accommodation preferred Ward Semi-private Private		Insurance attached No Yes		
Emergency Contact Information				
Next of kin/primary contact		Relationship		
Address		City	Prov.	Postal Code
Telephone (home)		Telephone (work)		Ext.
Power of Attorney (Please attach information)	Personal Care Name: Contact #	Financial Name: Contact #		
Advanced Care Directives in place (Please attach information)		☐ Yes ☐ No (Please note, resuscitation is not a treatment option for EOL care)		

Exclusion Criteria

- **Those exhibiting violent or exit-seeking behaviors with tendency to harm self, others or property**
- **The patient is receiving curative disease modifying treatment**
- **Test positive (+) for C. Difficile (Hospice Wellington & Lisaard House only)**

□ Current Isolation Issues: **□ Yes □ No** **Positive for:** **□ MRSA □ VRE □ C Diff. □ Other**	**□ Outstanding Medical Investigations:** _____ _____

(Patient Name/Label)

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Admission Location Requested:	☐ GRH Freeport-Kitchener ☐ SJHCG-Guelph ☐ GMCH-Fergus ☐ Lisaard House –Cambridge ☐ Hospice Wellington-Guelph
Referral Source:	
Facility / Community Agency:	Designation:
First Contact Person (Referral Source):	
Phone: ext:	Pager: Fax:
Second Contact Person (Referral Source):	
Phone: ext:	Pager: Fax:
Primary Palliative Diagnosis:	
Metastatic Spread (if malignant)	
Relevant Co-morbidities	
Reason for Referral	☐ Back Up Plan ☐ Uncontrolled Pain & Symptom Management ☐ End of Life Care (EOL) *EOL care includes ongoing pain & symptom management* ☐ EOL care needs exceed capacity of care at home ☐ Caregiver/s and/or support system inability to cope at home ☐ Individual does not wish to die at home ☐ Other (specify) _____
Prognosis	*Most recent PPS Score:* _____ *date of last assessment*_____ *PPS Scores over last month*_____ _____ _____ _____ *PPI Score:*_____ *(if available)* *Prognosis:* ❑ < 1 month ❑< 3 month ❑ < 6 months as determined by: Palliative Health Care Practitioner _____ *Individual aware of:* ❑Diagnosis ❑Prognosis ❑Does not wish to know *Family are aware of:* ❑ Diagnosis ❑ Prognosis ❑ Does not wish to know *If family is not aware, individual has given consent to inform family of:* Diagnosis ❑ Yes ❑ No Prognosis ❑ Yes ❑ No

(Patient Name/Label)

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Discharge Potential

Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met

Yes ☐

No ☐ What are the barriers for discharge?

_____

Care Issues
(please check all that apply)

- ❑ Pain & Symptom Control
- ❑ EOL Care/Death Management
- ❑ Loss & Grief (legacy work, anticipatory grief work)
- ❑ Disease management
- ❑ Spiritual Care
- ❑ Social Work
- ❑ Psychological

Special care considerations (please check all that apply and elaborate)

❑ Allergies:	❑ Central line: ❑ IV: ❑ Pain pump:
❑ Diet: ❑ Tube feed:	❑ Wound: ❑ Drains:
❑ Hydration ❑ Transfusion	❑ Dialysis Run/day/time:_____ ❑ PD ❑ Hemodialysis Review by renal team required. Note: Dialysis is not a treatment option for EOL care.
❑ Oxygen: ❑ Tracheotomy:	❑ Ongoing treatment for symptom relief (Chemo, radiation):
❑ Cognition/Dementia Issues _____ _____	❑ Pacemaker ❑ Internal defibrillator Has it been deactivated ❑ yes ❑ no

RELEVENT ATTACHMENTS (please provide the following if not available to the receiving organization electronically)

- ☐ Most recent/relevant Patient History / Consultation reports
- ☐ Copy of Consent Form
- ☐ MAR / Home Medication List
- ☐ Most recent Physician, Nursing, Allied Health Progress Notes

FAX COMPLETED FORM TO:

Freeport: 519-749-4326 GMCH: 519- 843-7206 SJHCG: 519-767- 4151 Lisaard: 519-650-8058
Hospice Wellington Residence: 519-822-2660

CONSENT

Palliative Care Hospice & In-Patient Referral

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
☐ Palliative Care	☐ Grand River Hospital – Freeport, Kitchener ☐ Groves Memorial Community Hospital – Fergus ☐ Hospice Wellington - Guelph ☐ Lisaard House - Cambridge ☐ St. Joseph's Health Centre - Guelph

I understand this means:

1. **I have discussed the requested program with**

   _____.
   (Print Name of Referral Source)

2. **I fully understand what the program is and what is expected of me as a patient participating in the program.**

I authorize the release of my personal and medical information to the requested program.

Name of Power of Attorney/Substitute Decision Maker (if applicable):

_____

_____ _____
Signature of Patient/Power of Attorney/Substitute Decision Maker **Date**

_____ _____
Signature of Witness **Date**

_____ _____
Name of Individual Obtaining Consent **Date**