Palliative Care Common Referral Form

Trent Hills Palliative Care Network

Addressograph

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 which 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 below. If urgency request is within 1-2 days, a phone contact must be made directly to the service request.

Types(s) of services requested	Urgency of response	Pages Required
☐ **Community Care Access Centre** (complete CCAC Medical Referral Form):	☐1-2 days ☐1-2 weeks	Page 1-4
☐ **Campbellford Memorial Hospital** (direct admit for symptom management):	☐1-2 days ☐1-2 weeks ☐Future	Page 1-3
☐ **Hospice Program** (home visiting):	☐1-2 days ☐1-2 weeks ☐Future	Page 1-4
☐ **Residential Hospice**:	☐1-2 days ☐1-2 weeks ☐Future	Page 1-3
☐ **Other** (specify):	☐1-2 days ☐1-2 weeks ☐Future	Page 1-3

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Individual's First & Last Name:

Home Address: _____ **Apt:**_____ **Entry Code:**_____ **Postal Code:**_____

☐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 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

Please list *all* Providers and Services currently involved: (if known) ☐ Additional list attached

Name	Phone	Fax
Family Physician:		
CCAC		
Community Nursing		
Hospice		
Other		

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Individual's First & Last Name:

Co-Morbidities: ☐ Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(specify precaution)*: _____

Allergies: ☐ Yes, specify:_____ ☐ No ☐ Unknown

Pharmacy (name and number) 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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Individual's First & Last Name:

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 _____ Nausea _____ Depression _____ Drowsiness _____

Appetite _____ Well-being _____ Shortness of Breath _____ Other: _____

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: _____ Tel: _____ Fax: _____

(Referring) Physician: _____ Tel: _____Fax: _____

Date of Referral: (DD/MM/YY): _____

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