Madawaska Valley Hospice Palliative Care
Individual Compassionate Support at Every Step

PALLIATIVE CARE REFERRAL

FAX: 613-756-0106
PHONE: 613-756-3045 ext. 350

Please contact MVH at the number above prior to submitting referral for Hospice Admission

CLIENT INFORMATION

Surname ☐Mr. ☐Mrs. ☐Miss ☐Ms.	Given Name	Age	DOB yy/mm/dd	Sex ☐F ☐M

Address	City	Prov.	Phone Number
Postal Code			

Current Location: ☐ Home ☐ SFMH ☐ VM ☐ WTL Room # _____ Other _____

Ontario Health Card No.	Version Code	Preferred Language ☐English ☐French ☐Other:

Client is aware, agreeable and consents to referral and sharing of health information? ☐ Yes If no, unable to proceed with referral.

FAMILY PHYSICIAN

Name:	Phone:	Fax:

REASONS FOR REFERRAL (Please check all that apply)

Diagnosis: _____ **ALLERGIES**: _____

☐ Caregiver Stress ☐ Function and Support ☐ Urgent End-of-Life Assist ☐ Advance Care Planning ☐ Hospice Admission
☐ Bereavement Support ☐ Other:

☐ Check if referral is urgent; What issues make this referral urgent?

SIGNIFICANT MEDICAL HISTORY (including recent changes)

1	2	3
4	5	6

Current Functional Status at time of referral: Palliative Performance Scale

PPS: 10% ____ 20% ____ 30% ____ 40% ____ 50% ____ 60% ____ 70% ____ 80% ____ 90% ____ 100% ____

YOUR GOALS AND EXPECTATIONS FOR HOSPICE to ACCOMPLISH

ALTERNATE CONTACT PERSON INFORMATION

Name:		Relationship of Client:	
Phone: Home:	Work:	Cell:	Email:

Who should be contacted for appointment? ☐ Client ☐ Other:

REFERRAL SOURCE

Name:	Relationship to Client	Phone/Ext.	Fax:

Printed Name	Signature	Referral Date yyyy/mm/dd