

**Aging Well Clinic**
**Non-Malignant Palliative Care Referral**
**Fax completed forms to: 905-952-2453**

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: (Print first, last) _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

**Service Description**

The clinic provides supportive care and symptom management for individuals with advanced, non-malignant illness where on-going disease progression is expected, or for those showing signs of poor prognosis. With a focus on quality of life, we help patients understand their anticipated illness trajectory and support them in preparing for disease progression and the final stages of their illness.

**Conditions we commonly support include:**

- Advanced cardiac or respiratory disease
- End-stage renal or liver disease
- Progressive neurological conditions (e.g., Parkinson's disease, multiple sclerosis, motor neuron disease)
- Frailty
- End-stage dementia

The clinic **does not** offer support for chronic pain management or assume primary care (i.e., chronic disease management).

***Incomplete and/or out of catchment referrals will be returned.***

**Patient Information:**

Patient Name: (print first, last) \_\_\_\_\_

Address:	Street Number + Name	Apartment
City	Province	Postal Code
Health Card Number:	Version Code:	Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Patient Phone #: ( )	Marital Status:	Gender:

**Primary Caregiver/Primary Contact**

Name: (print first, last) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**Scheduling Information:**
 Book the appointment directly with the patient  Book the appointment with an alternate contact

Name: _____	
Relation: _____	Phone #: ( ) _____
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language: _____



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## Non-Malignant Palliative Care Referral

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<b>Life Limiting Diagnosis:</b>		
<b>Reason for Referral:</b> <i>(check all that apply)</i>		
<input type="checkbox"/> Symptom management	<input type="checkbox"/> Other:	_____
<input type="checkbox"/> Serious illness conversation including goals of care & advanced care planning		_____
<input type="checkbox"/> Implement plan for end of life care		_____
<input type="checkbox"/> Link with community palliative care supports		
<input type="checkbox"/> Support for caregivers and families		
<input type="checkbox"/> Discuss alternatives to MAID		
<b>Referral Information:</b> <i>(please provide as much information as possible to support the referral)</i>		
<b>Anticipated Prognosis:</b>	<b>Palliative Performance Scale (PPS):</b>	<b>Level of Care Preferences:</b>
<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> 10% <input type="checkbox"/> 30% <input type="checkbox"/> 50% <input type="checkbox"/> 70% <input type="checkbox"/> 90%	<input type="checkbox"/> Full code or critical care
<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> 20% <input type="checkbox"/> 40% <input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 100%	<input type="checkbox"/> Medical care with DNR
<input type="checkbox"/> Less than 6 months		<input type="checkbox"/> Comfort care (end of life care) with no further transfers back to hospital
<input type="checkbox"/> Less than 12 months		<input type="checkbox"/> Unknown
<input type="checkbox"/> Less than 24 months		
Is the patient homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Past Medical History:</b>		
Please attach the following information (unless accessible on Connecting Ontario/Meditech):		
<ul style="list-style-type: none"> <li>• Past medical history</li> <li>• Medication list</li> <li>• Relevant investigations</li> <li>• Consultations and specialist notes</li> </ul>		
<b>Consent for Referral Obtained From:</b>		
<input type="checkbox"/> Patient <input type="checkbox"/> SDM/POA    Date: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Referring Provider: <i>(print first, last)</i>		Primary Care Provider if not Referring Provider: <i>(print first, last)</i>
Signature of Referring Provider:		
Billing #:		Phone Number: (    )
Phone Number: (    )	Fax Number: (    )	Fax Number: (    )

