

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>

Hospice Palliative Care Team Referral Form

Please fax to 905-830-5978

Date of Referral: (dd/mm/yyyy) ____ / ____ / ____		Urgency: <input type="checkbox"/> 1-2 days <input type="checkbox"/> within 1 week <input type="checkbox"/> 1-2 weeks	
Patient Name: (print first, last)			
Address:		Street Number + Name	Apartment
City		Province	Postal Code
Health Card Number:	Version Code:	Date of Birth (dd/mm/yyyy): ____ / ____ / ____	
Home Phone: ()	Alternate Phone: ()	Gender at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Primary Contact Person Name/Relationship:		Phone: ()	
Primary Care Physician Name:		Phone: ()	
Is a Home Visiting Physician assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician:	Phone: ()	
REASON FOR REFERRAL:			
<input type="checkbox"/> Pain and Symptom Management Consultation	<input type="checkbox"/> Referral to Palliative Physician		
<input type="checkbox"/> Other - please specify:			
PRIMARY PALLIATIVE DIAGNOSIS:			
Other Relevant: Diagnosis/Symptoms:			
If Cancer Diagnosis - Metastatic Spread: <input type="checkbox"/> Yes <input type="checkbox"/> No Sites:			
If Cancer Diagnosis Ongoing Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:			
Individual aware of diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not wish to know		
Family are aware of diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No If family is not aware, individual has given consent to inform family of diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Individual aware of prognosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not wish to know		
Anticipated Prognosis:	<input type="checkbox"/> Less than 1 month <input type="checkbox"/> Less than 3 months <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than 12 months <input type="checkbox"/> Uncertain		
Resuscitation Status:	Do Not Resuscitate <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Discussed With:	Individual: <input type="checkbox"/> Yes <input type="checkbox"/> No Family: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospice Referral:	Name:	Phone Number: ()	
Psychosocial:			
Current Medications:			
PRESENTING SYMPTOMS (ESAS Scores): Rate symptoms: 0 =no symptom, 10 =worst symptom			
Pain: ____/10	Tiredness: ____/10	Nausea: ____/10	Depression: ____/10
Anxiety: ____/10	Drowsiness: ____/10	Appetite: ____/10	Wellbeing: ____/10
SOB: ____/10	Other: ____/10		
Palliative Performance Scale (PPS) <input type="checkbox"/> 10% <input type="checkbox"/> 20% <input type="checkbox"/> 30% <input type="checkbox"/> 40% <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%			
Patient receiving Ontario Health at Home Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Care Coordinator Name:	
Nursing Agency:		Nurse Name:	
REFERRAL SOURCE			
Form completed by:		Signature:	
Date of Referral: (dd/mm/yyyy) ____ / ____ / ____	Phone: ()	Fax: ()	
Referring Physician		Billing #:	
Phone: ()	Fax: ()	Physician Signature:	

