SouthlakeHealth

Hospice Palliative Care Team
596 Davis Drive
Newmarket, ON L3Y 2P9
Tel: 905-895-4521, ext. 6388
Fax: 905-830-5978

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: (Print first, last) _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Hospice Palliative Care Team Referral Form

Please fax to 905-830-5978

Date of Referral: *(dd/mm/yyyy)* ____ / ____ / ____ **Urgency:** ❑ 1-2 days ❑ within 1 week ❑ 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: ❑ Female ❑ Male
Primary Contact Person Name/Relationship:		Phone: ( )
Primary Care Physician Name:		Phone: ( )
Is a Home Visiting Physician assigned? ❑ Yes ❑ No	Physician:	Phone: ( )

REASON FOR REFERRAL:
❑ Pain and Symptom Management Consultation ❑ Referral to Palliative Physician
❑ Other - please specify:

PRIMARY PALLIATIVE DIAGNOSIS:	
Other Relevant: Diagnosis/Symptoms:	
If Cancer Diagnosis - Metastatic Spread:	❑ Yes ❑ No *Sites:*
If Cancer Diagnosis Ongoing Treatment:	❑ Yes ❑ No *Describe:*
Individual aware of diagnosis:	❑ Yes ❑ No ❑ Does not wish to know
Family are aware of diagnosis:	❑ Yes ❑ No *If family is not aware, individual has given consent to inform family of diagnosis:* ❑ Yes ❑ No
Individual aware of prognosis:	❑ Yes ❑ No ❑ Does not wish to know
Anticipated Prognosis:	❑ Less than 1 month ❑ Less than 3 months ❑ Less than 6 months ❑ Less than 12 months ❑ Uncertain
Resuscitation Status:	Do Not Resuscitate ❑ Yes ❑ No ❑ Unknown
Discussed With:	Individual: ❑ Yes ❑ No Family: ❑ Yes ❑ 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	SOB: _____ /10
Anxiety: _____ /10	Drowsiness: _____ /10	Appetite: _____ /10	Wellbeing: _____ /10	Other: _____ /10

Palliative Performance Scale (PPS) ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Patient receiving Ontario Health at Home Services? ❑ Yes ❑ 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: