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 - *call HPCT & indicate reason for urgency* ❑ 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 |
| **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: |

S-REFE