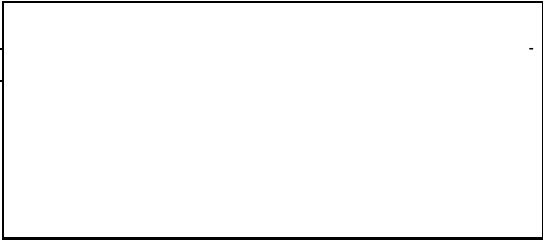


TO ALL PALLIATIVE CARE PROVIDERS

(For the purpose of this Form, an individual refers to a patient or client)



Your submission of this form will be taken to explicitly mean that you have gained appropriate permission for release of the information contained to the agencies and services to whom you are submitting this. Please also include your Organization's Release of Information Form, if applicable.

Please complete this form as thoroughly as possible and PRINT clearly. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section.

Individual's Last Name: _____ **First Name:** _____

Goals of Care/ Reason for Referral:

Application Checklist (include if available):

- Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)
- Communication to the individual's family physician of referral for palliative care services
- Copy of completed Do Not Resuscitate Confirmation Form
- Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) Recent chest x-ray
- Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.**
- Recent consultation notes Recent laboratory results Pathology reports

Note: Referral Source must be responsible to send referral to all services requested as indicated below. If urgency request is within 1-2 days, a phone contact must be made directly to the service request.

Type(s) of services requested	Urgency of response	Pages Required
<input type="checkbox"/> Home and Community Care Support Services (complete Medical Referral):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks	Page 1-4
<input type="checkbox"/> Community Palliative Care Physician (Specify Palliative Physician Team): Referral is for: <input type="checkbox"/> Consultative care <input type="checkbox"/> Primary care	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks	Page 1-3
<input type="checkbox"/> Hospice Program: <input type="checkbox"/> Home Visiting <input type="checkbox"/> Day Program <input type="checkbox"/> Residential Hospice (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future <input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	Page 1-4
<input type="checkbox"/> Inpatient Palliative Care Unit (List all units referred):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	Page 1-4
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	Page 1-4

**Please send directly to your desired hospice palliative care provider(s).
Do not send to the Toronto Central Hospice Palliative Care Network.**

Individual's First & Last Name: _____

Home Address: _____ Apt: _____ Entry Code: _____ Postal Code: _____

Lives Alone Young Children in the Home Smoking in the Home Pet in the Home (specify): _____

Home phone number: _____ Alternate number: _____

Date of birth: (DD/MM/YY) _____ Gender: _____ Faith/Religion: _____

Health card number: _____ Version code: _____

Primary language(s): _____ Translator: (name/phone #): _____

Current location: Home Residential hospice Other (specify address): _____
 Hospital Anticipated hospital discharge date: _____

Primary palliative diagnosis: _____ Date of Diagnosis _____

Other relevant diagnosis/symptoms: _____

If cancer diagnosis: metastatic spread: Yes No Describe: _____

If cancer diagnosis: ongoing treatment: Yes No Describe: _____

Individual aware of: Diagnosis: Yes No Prognosis: Yes No Does not wish to know: Yes No

Family are aware of: Diagnosis: Yes No Prognosis: Yes No Does not wish to know: Yes No

If family is not aware, individual has given consent to inform Family of: Diagnosis Yes No Prognosis Yes No

Anticipated prognosis: < 1 month < 3 months < 6 months < 12 months Uncertain
 Determined by (name and phone number): _____

Functional status: Palliative Performance Scale (PPS): refer FAQs for more details

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

Resuscitation status: Life Support Decision: CPR No CPR Unknown Decision

Discussed with: Individual Yes No Family Yes No

Family/Informal Caregivers: Provide Power Of Attorney for Personal Care if known: _____

Name	Relationship	Home Phone	Business/Cell Phone

Please list all Providers and Services currently involved: (if Known) Additional list attached

Name	Phone	Fax
Family Physician:		
Nurse Practitioner:		
Care Coordinator*		
Community Nursing		
Hospice		
Other		

*Home and Community Care Support Services

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Individual's First & Last Name:

Co-Morbidities: Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

Infection Control: MRSA/VRE (+) C-DIFF (+) Other (specify precaution): _____

Allergies: Yes No Unknown If Yes (please specify): _____

Pharmacy (name and number) If Known: _____

Current medications: medication list attached

(Include complementary alternative medications and over-the-counter medications)

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Details of social situation, including any needs/concerns of the family:

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Individual's First & Last Name:

Special care needs: (please check all that apply)

- Transfusion, Hydration, SC or IV, Infusion pump(s), Total Parental Nutrition, Enteral feeds, Dialysis, Central line(s), P.I.C.C. line(s), PortaCath, Tracheostomy, Oxygen: rate, Thoracentesis, Paracentesis, Drains/Catheter, Wound care, Therapeutic surface, Other needs.

Symptom assessment:

ESAS Score at the time of referral: (Adapted from Edmonton Symptom Assessment System—ESAS, Capital Health, Edmonton) (rate symptoms: 0 = no symptom, 10 = worst symptom possible – See FAQs for details):

Pain, Tiredness, Nausea, Depression, Anxiety, Drowsiness, Appetite, Well-Being, Shortness of Breath, Other.

Date ESAS completed:

Insurance Information:

Has expressed willingness to pay for private services: Yes No Not Known

For inpatient palliative care units: Private accommodation requested

Any additional information:

Large empty box for additional information.

Individual Completing Form: (Referring) Physician: Tel: Fax:

Date of Referral: (DD/MM/YY)

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