

Hospice Referral Form

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	Emmanuel House	Carpenter House	Hospice Niagara	McNally House	Bob Kemp	Stedman	Margaret's Place
Fax #	905-308-8116	905-631-7107	905-646-3860	905-309-6656	905-318-8411	519-751-7527	905-627-6577

Patient Information	BRN#
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Patient Name _____ **HCN** _____ **VC** _____ **DOB** _____
Address _____ **City** _____ **Province** _____ **Postal Code** _____
Patient Phone # _____ **Current Location** _____
SDM _____ **Relationship** _____ **Phone** _____
Preferred Language _____ **Gender Identity** _____
Care Coordinator _____ **Phone** _____ **Ext.** _____

Service(s) Requested (please check all that apply)

- Residence Bed
 Day Program
 Outreach Team
 Visiting Volunteer
 Bereavement
 Psychosocial Spiritual

Primary Community Health Care Provider Information

Community MRP Name _____ **MRP aware of referral request?** Yes No Unknown
MRP Phone _____ **Backline or Cell** _____ **MRP Fax** _____
Primary Specialist _____ **Phone** _____ **Fax** _____

Medical Information

Primary Diagnosis _____ **Date of Onset** _____ **PPS** _____
Secondary Diagnoses / Comorbidities _____
Allergies _____
Symptoms Requiring Management (nausea, pain, etc.) _____

Patient & Family's Goals & Expectations _____

Other Relevant Information _____ **DNR** Yes No

History of:
 MRSA Yes No Unknown
 VRE Yes No Unknown
 C-Diff Yes No Unknown

COVID Vaccination Unimmunized Partially Immunized Fully Immunized
Date of Last Dose: _____

Attachments Medical Summary / Health History Consult / Progress Notes Other Notes Pertinent Diagnostic Tests
 Current Medication List Pharmacy

Referral Source

Referring Practitioner Name _____ **Position** _____
Organization _____ **Phone** _____ **Ext.** _____
Signature _____ **Date** _____



Patient Name _____ BRN # _____

Palliative Performance Status (PPS) Guide

(✓)	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
	80%	Full	Normal activity <i>with Effort</i> Some evidence of disease	Full	Normal or reduced	Full
	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
	60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance	Normal or reduced	Full or Confusion
	50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
	40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
	30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
	20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
	10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Full or Drowsy +/- Confusion
	0%	Death				

Hospice Services Available by Location

Hospice	Location	Phone Number	Residence Beds	Day Programs	Outreach Team	Visiting Volunteer	Psychosocial Spiritual Bereavement
Emmanuel House	Hamilton	905-308-8401	Yes	No	Yes	No	Yes
McNally House	Grimsby	905-309-4013	Yes	No	No	No	Yes
Hospice Niagara	St. Catharines	905-984-8766	Yes	Yes	Yes	Yes	Yes
Carpenter Hospice	Burlington	905-631-9994	Yes	Yes	Yes	No	Yes
Bob Kemp	Hamilton	905-387-2448	Yes	Yes	Yes	Yes	Yes
Stedman	Brantford	519-751-7096 ext. 2500	Yes	Yes	Yes	No	Yes
Margaret's Place	Hamilton	905-627-6577	Yes	Yes	Yes	No	Yes

Referral Eligibility for Hospice Residence Confirmed by

Care Coordinator _____ Date _____ Phone # _____