Palliative Care Common Referral Form

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.

Applicant:  
(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 above; if urgency request is within 1-2 days, a phone contact must be made to the service request.

<table>
<thead>
<tr>
<th>Type(s) of Services Requested</th>
<th>Urgency of Response</th>
<th>Pages Required</th>
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</thead>
</table>
| □ Community Care Access Centre  
 (Complete CCAC Medical Referral Form): | □ 1-2 Days □ 1-2 Weeks | Page 1-4 |
| □ Community Palliative Care Physician  
 (Specify Palliative Physician Team): | □ 1-2 Days □ 1-2 Weeks □ Future | Page 1-3 |
| Referral is for: □ Consultative Care □ Primary Care | | |
| □ Hospice Program  
 □ Home Visiting  
 □ Day Program  
 □ Residential Hospice (specify): | □ 1-2 Days □ 1-2 Weeks □ Future | Page 1-4 |
| □ Inpatient Palliative Care Unit (List all units referred): | □ 1-2 Days □ 1-2 Weeks □ Future | Page 1-4 |
| □ Other (specify): | □ 1-2 Days □ 1-2 Weeks □ Future | Page 1-4 |

- Please send directly to your desired hospice palliative care provider(s)
- For application to Matthews House Hospice please fax to the Central CCAC at Fax (416) 222-6517 or Fax (905) 952-2404
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Applicant: (Last Name, First Name)

Home Address (Street No./St. Name/Bldg.) Apt/Suite# Entry Code

City Postal Code Telephone
(Home):
(Other):

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

Date of Birth: (dd-mmm-yyyy) Gender: ☐ Male ☐ Female Faith/Religion:

Health Card Number: Version Code:

Primary Language: Translator:

Other Languages:

Name:

Tel:

Current Location:

☐ Home ☐ Residential Hospice ☐ Other (specify address):

☐ Hospital (Name of Hospital) Anticipated Hospital Discharge Date: (dd-mmm-yyyy)

Primary Palliative Diagnosis: Date of Diagnosis: (dd-mmm-yyyy)

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: Do Not Resuscitate ☐ Yes ☐ No ☐ Unknown

Discussed with: Individual ☐ Yes ☐ No Family ☐ Yes ☐ No

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

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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Business/Cell Phone</th>
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Applicant: 
(Last Name, First Name)

Please list all Providers and Services currently involved; if known: ☐ Additional List Attached

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<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Family Physician:</td>
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<td>CCAC:</td>
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<td>Community Nursing:</td>
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<td>Hospice:</td>
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<td>Other:</td>
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Co-Morbidities: ☐ Check here if documentation is attached.

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<thead>
<tr>
<th>Year</th>
<th>Diagnosis</th>
<th>Year</th>
<th>Diagnosis</th>
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Infection Control:
☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other (specify precaution): ____________________________

Allergies:
☐ Yes ☐ No ☐ Unknown If Yes (please specify): ____________________________

Pharmacy (Name & Tel. No.) If Known: ____________________________

Current medications: ☐ Medication List Attached
(Include complementary alternative medications and over-the-counter medications)

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<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Interval</th>
<th>Drug</th>
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<th>Route</th>
<th>Interval</th>
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Details of social situation, including any needs/concerns of the family:

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Applicant: (Last Name, First Name)

Special Care Needs: (please check all that apply)
- Transfusion
- Hydration: sc or IV
- Infusion pump(s)
- Total Parenteral Nutrition
- Enteral feeds
- Dialysis
- Central line(s)
- P.I.C.C. line(s)
- PortaCath
- Tracheostomy
- Oxygen: Rate: ___
- Thoracentesis
- Paracentesis
- Drains/Catheter (specify): __________
- Wound care (specify): __________
- Therapeutic surface (specify):
- 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)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
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<tbody>
<tr>
<td>Pain</td>
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<td>Tiredness</td>
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<td>Drowsiness</td>
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<td>Nausea</td>
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<td>Lack of Appetite</td>
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<td>Shortness of Breath</td>
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<td>Depression</td>
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<td>Anxiety</td>
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<td>Well-being</td>
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<td>Other</td>
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Date ESAS Completed: ________  Insurance Information: __________
(dd-mmm-yyyy)

Applicant/Family has expressed willingness to pay for private services:
- Yes  ☐ No  ☐ Not Known

For inpatient palliative care units: ☐ Private accommodation requested

Any Additional Information:

Applicant Completing Form: ____________________________
Signature

(Referring) Physician: ____________________________
Signature

Tel: __________
Fax: __________

Date of Referral: ________  (dd-mmm-yyyy)

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