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Name _____
Address _____
City _____ PC _____
Phone _____ DOB _____
HCN _____ VC _____
OHIP: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> WSIB <input type="checkbox"/> FIHP <input type="checkbox"/> MVA

Request for Hospice Palliative Care Services

Referral from Community Referral from Hospital

Family Physician Name _____ Phone Number _____ **Aware of Referral**

Substitute Decision Maker (SDM) Name _____ Relationship _____ Phone _____

Patient Communication Needs (e.g. Language, hearing): _____

Requested Service(s)	Reason for Referral/Goals of Care:
<p>If urgent HPC physician care is required contact the physician directly. *Call WWLHIN if phone number needed.</p> <p>Referring Physician please complete: Community MRP Name: _____ <i>(must have clinician available to nursing 24/7 on call)</i> Available to make house calls? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please choose one: <input type="checkbox"/> Palliative Physician provides consultation and ongoing care* if appropriate <input type="checkbox"/> Shared Care with Palliative Physician <i>* Palliative physician role in ongoing care is determined after consultation. If palliative physician agrees to assume MRP, other physicians agree to stop billing G512 code</i></p> <p>HOME AND COMMUNITY CARE SERVICES <input type="checkbox"/> Hospice Palliative Care Nurse Practitioner <input type="checkbox"/> Palliative Nursing <i>(24/7 MRP required)</i> <input type="checkbox"/> Personal Support Services <input type="checkbox"/> SLP <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/> Spiritual Care <input type="checkbox"/> Hospice Volunteer Program</p>	<p>Patient/SDM consented to referral <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Primary Diagnosis: _____ Date: _____</p> <p>Prognosis: _____</p> <p><input type="checkbox"/> Patient Aware <input type="checkbox"/> Family Aware</p> <p>DNR-C Complete? <input type="checkbox"/> Yes (please include with referral) <input type="checkbox"/> No Resuscitation Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family</p> <p>Patient receiving care at Regional Cancer Centre? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Other _____</p> <p>Facility: _____</p>

Symptom Screening

Functional Status: *Palliative Performance Scale (PPS)* % _____

ESAS-r: 0 = no symptom; 10 = worst symptom possible *(reported by patient at time of referral)*

Pain ____ Fatigue ____ Drowsiness ____ Nausea ____ Appetite ____ SOB ____ Depression ____ Anxiety ____ Wellbeing ____

Supporting Documentation (NOTE: Do Not include if available via Clinical Connect)

<input type="checkbox"/> Current Medication <i>(includes alternative/OTC)</i>	<input type="checkbox"/> Care protocols e.g. wound, central line, drainage <i>(pleural ascetic fluid management)</i>
<input type="checkbox"/> Cumulative Patient Profile <i>(Long Format)</i>	<input type="checkbox"/> Infection control management (e.g. MRSA/VRE/C-Diff) and treatment provided; current within 2 weeks of referral
<input type="checkbox"/> Recent consultation notes <i>(including medical oncology consultation)</i>	<input type="checkbox"/> Advance Care Planning (ACP) conversation documentation
<input type="checkbox"/> Diagnostic imaging <i>(X-ray, Ultrasound, CT scan, MRI)</i>	
<input type="checkbox"/> Recent laboratory and pathology reports	

Name (please print) _____ MD RN(EC) Phone# (Private) _____

Signature _____ Date _____ Physician Billing/CNO# _____