

Palliative Care Hospice and In-Patient Referral

Date of Application:		Date of Admission:		BRN:	
Personal Information					
Last Name			First Name		
Date of Birth			Age		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address			Unit #	City	Prov. Postal Code
Home Telephone			Present Location (home, hospital, LTC, ED)		
Family Physician/Primary Care Practitioner			Phone		Fax
Most Responsible Physician			Phone		Fax
Nurse Practitioner			Phone		Fax
Health Insurance Information					
Is patient covered under Ontario Health Insurance Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		Last name on health card:		Health Insurance Number	Version Code
Accommodation preferred: <input type="checkbox"/> Ward <input type="checkbox"/> Semi-private <input type="checkbox"/> Private				Insurance attached: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Primary Contact Information					
Name		Relationship		Substitute Decision Maker (SDM) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Power of Attorney for Personal Care? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)		Power of Attorney for Property Decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)			
Address		City	Prov.	Postal Code	
Telephone (home) Telephone (cell)		Telephone (work)			Ext.
Alternate Contact Information					
Name		Relationship		Substitute Decision Maker (SDM) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Power of Attorney for Personal Care? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)		Power of Attorney for Property Decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)			
Address		City	Prov.	Postal Code	
Telephone (home) Telephone (cell)		Telephone (work)			Ext.
Patient/SDM (if mentally incapable) requesting resuscitation or other life sustaining interventions? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note, resuscitation is not a treatment option for EOL care)					
Current Isolation Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No			Positive for: <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C Diff. <input type="checkbox"/> Other (C Diff is an exclusion criteria for all hospice sites)		
Outstanding Medical Investigations:					
FAX COMPLETED FORM TO LHIN 519-742-0635					

(Patient Name/Label)

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Admission Location Requested:	Please select the patient's site choice. For multiple choices, please rank site choice from 1 to 6. (1= First choice, 2= Second choice, 3= Third choice, 4 = Fourth choice, 5 = Fifth choice, 6 = Sixth choice)	
	Lisaard House - Cambridge <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th	Hospice Wellington - Guelph <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th
	Innisfree House - Kitchener <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th	SJHCG - Guelph <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th
	GRH Freeport - Kitchener <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th	GMCH- Fergus <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th

Mandatory Field- Priority Ranking- Check one of the following:

Priority 1- Crisis
 Priority 2- Non-Crisis
 Priority 3- Back-up Plan (End of Life- Hospice only)

Referral Source :

Hospital In-patient unit
 Hospital – ED
 Community

Facility/Community Agency: _____ Location/Unit: _____

Referral Source Contact Person: _____

Phone: _____ ext: _____ Pager: _____ Fax: _____

Bed Offer Contact Person: _____

Phone: _____ ext: _____ Pager: _____ Fax: _____

Primary Palliative Diagnosis: _____ **Date of Diagnosis:** _____

Metastatic Spread (if malignant) _____

Relevant Co-morbidities

Reason for Referral

Pain & Symptom Management: Time-limited for uncontrolled symptoms in person with life threatening illness. When stabilized, patients are assessed for discharge. ESAS: (attach if available)
 What are the symptoms that require management? _____

End of Life Care/Hospice (EOL): Range of palliative care to meet the needs of patients at end of life.
 EOL care needs exceed capacity of care at home
 Caregiver/s and/or informal supports inability to cope at home
 Individual does not wish to die at home
 Other (specify): _____

Back Up Plan (Hospice sites only)

Prognosis

Most recent PPS Score: _____ Date of last assessment _____
 PPS Scores over last month (if available) _____
 Over last _____, oral intake has Increased Decreased No change
 Prognosis: < 1 month < 3 month < 6 months
 as determined by: Palliative Health Care Practitioner _____

Individual aware of: Diagnosis Prognosis Does not wish to know
 Family are aware of: Diagnosis Prognosis Does not wish to know

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

(Patient Name/Label)

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Care Issues (please check all that apply)	<input type="checkbox"/> EOL Care/Death Management <input type="checkbox"/> Pain & Symptom Management Beds <input type="checkbox"/> Disease Management <input type="checkbox"/> Spiritual Care <input type="checkbox"/> Social Work <input type="checkbox"/> Psychological <input type="checkbox"/> Loss & Grief (legacy work, anticipatory grief work) <input type="checkbox"/> Encouraged Advance Care Planning Conversations between patient and Substitute Decision Maker <input type="checkbox"/> Reviewed role of Substitute Decision Maker with the patient's SDM	Is there a known patient goal to access medical assistance in dying? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, requires further conversations with receiving sites.
Discharge Potential (only applicable for Pain & Symptom management)	Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met? Yes <input type="checkbox"/> No <input type="checkbox"/> What are the barriers for discharge to the previous living arrangements? What are the alternate options? <input type="checkbox"/> Patient/SDM are aware that if the symptoms stabilize, discharge planning will proceed. Please provide specific details:	
Special care considerations (please check all that apply and elaborate) *Early consultation required for patients with oxygen greater than 6L/min to support safe transportation and oxygen delivery in the Hospice setting	<input type="checkbox"/> Allergies:	<input type="checkbox"/> Central line: <input type="checkbox"/> IV: <input type="checkbox"/> Pain pump:
	<input type="checkbox"/> Diet: <input type="checkbox"/> Tube feed:	<input type="checkbox"/> Wound: <input type="checkbox"/> Drains:
	<input type="checkbox"/> Hydration <input type="checkbox"/> Transfusion	<input type="checkbox"/> Dialysis Run/day/time: _____ <input type="checkbox"/> Peritoneal dialysis <input type="checkbox"/> Hemodialysis Dialysis Discontinuation Date: _____ Review by renal team required.
	<input type="checkbox"/> Oxygen: <input type="checkbox"/> Tracheostomy:	<input type="checkbox"/> Ongoing treatment for symptom relief (Chemo, radiation, Dialysis):
	<input type="checkbox"/> Cognition/Dementia Issues	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal defibrillator Has it been deactivated <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Additional equipment required?	
RELEVANT ATTACHMENTS (please provide the following if not available to the receiving organization electronically)		
<input type="checkbox"/> Most recent/relevant Patient History/Consultation reports <input type="checkbox"/> MAR/Home Medication List <input type="checkbox"/> Letter of Understanding <input type="checkbox"/> Most recent Physician, Nursing, Allied Health Progress Notes		

Palliative Care Hospice & In-Patient Letter of Understanding

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Grand River hospital- Freeport, Kitchener <input type="checkbox"/> Groves Memorial Hospital- Fergus <input type="checkbox"/> St. Joseph's Health Centre- Guelph <input type="checkbox"/> Hospice Wellington- Guelph <input type="checkbox"/> Lisaard House- Cambridge <input type="checkbox"/> Innisfree House- Kitchener

I understand this means:

1. I have discussed the requested program with

_____.
(Print Name of Referral Source)

2. I fully understand what the program is and what is expected of me as a patient participating in the program.

I authorize the release of my personal and medical information to the requested program.

Signature of Patient/Substitute Decision Maker

Consent obtained verbally

Date

Signature of Witness

Date

Name of Individual Obtaining Consent

Date

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How is Crisis defined?

A patient is considered to be "In Crisis" if:

1. Patient and/or caregiver safety is at risk and/or there is a risk that a significant health event and/or challenging end-of-life symptoms cannot be managed in their current setting
2. Patient at risk of requiring ED or acute care admission
3. Community resources have been exhausted and family/ caregivers are unable to cope with the patient's care needs
4. There is a risk that the services required to meet the patient's end-of-life care plan goals may not be available in their current setting
5. Patient at risk of not accessing their preferred place of death (considering recent trajectory of the PPS score).