Champlain

Regional Palliative Consultation Team

Referral Form can be found at www.bruyere.org

RPCT REFERRAL FORM

24-hour / 7days Telephone Consultation Service for Professionals

Tel: 613-562-6397 Fax: 613-562-6394

Tel: 1-800-651-1139 Fax: 1-844-689-1768

Ensure all sections are completed BEFORE faxing referral.
A Home and Community Care Support Services Champlain referral is required for RPCT services.
Attach pertinent information such as medication list or discharge summary, etc.

Call RPCT ONLY if urgent

PATIENT INFORMATION

Name of patient: _____ DOB: _____

Facility name _____

Address: _____ City: _____

Room/Apt/Unit#: _____ Postal Code: _____ Telephone: _____

OHIP #: _____ VC: ____ ❑ Male ❑ Female ❑ French ❑ English ❑ Other: _____

Language interpreter required: ☐ yes ☐ no

Referring Professional: _____

Location: _____

Tel #: _____ Fax #: _____

From: ❑ Primary Care Office ❑ Home and Community Care Support Services Champlain/ Nursing Agency
❑ Hospital ❑ EB PCU ❑ LTC Facility ❑ Retirement Home ❑ Hospice ❑ Other _____

Primary Care Physician/ NP following this patient:

Full Name: _____ Practitioner Billing # (if known): _____

Office #: _____ Fax #: _____

This patient needs to be assessed at the address below:

❑ Address (specify, if different from above): _____

For in hospital assessment (select one of the following):

❑ Almonte GH ❑ Arnprior RH ❑ Carleton Place MH ❑ Cornwall CH ❑ Deep River DH ❑ Glengarry MH
❑ Hawkesbury GH ❑ Kemptville DH ❑ Pembroke RH ❑ Renfrew VH ❑ Saint Francis MH ❑ Winchester DM
❑ Other: _____

Type of Life Limiting Diagnosis:

❑ Cancer (specify): _____ Metastatic sites: _____

❑ Non-Cancer (specify): _____

Reason for Consultation: ❑ Symptom Management ❑ EOL Care ❑ Complex Decision Making

PPS: ___% Condition changing: Daily ❑ Weekly ❑ Monthly❑

Main symptoms/palliative care issues (explain):

_____

_____

_____

_____

** Incomplete referrals will be returned, delaying the triage process **