REFERRAL FOR PALLIATIVE/END-OF-LIFE SERVICES

Patient Details and Demographics		
Health Card Number:	Version Code:	Date of Birth (DD/MM/YYYY):
Surname:	First name(s):	
Address:	City:	Province: Postal Code:
Phone #:	Alternate Phone #:	Primary Language: ☐English ☐French ☐Other
Gender: ☐Male ☐Female ☐ Unidentified ☐ Unknown		
Name of Contact Person (if other than Patient):		Phone #:
Relationship: ☐POA/SDM ☐Spouse ☐Other (specify):		Alternate Phone #:
Health Information		
Relevant diagnosis:	Reason for Referral:	
☐DNR in place ☐Patient/Family aware of diagnosis ☐In home pronouncement ☐End of Life Palliative Performance Score:		
Infection control: ☐MRSA Positive ☐VRE Positive ☐C diff ☐TB ☐Other:		Allergies:
Services Requested		
☐Nursing ☐Personal Support ☐Physiotherapy ☐Occupational Therapy ☐Social Work ☐Speech Language Pathology ☐Nutrition		
☐Nurse Practitioner Palliative Care *Sudbury, West Nipissing, Sault Ste. Marie, Timmins & District of Temiskaming only		
☐Assess for Alternate Programs: ☐Hospice *Sudbury, Sault Ste. Marie ☐Complex Continuing Care ☐LTC/Short-Stay Respite		

Previous Opioid Medication needed in last 24-hour period (oral conversion to subcutaneous): ___________________________________

►	**DRUG**	**BASAL INFUSION RATE:** For optimum management, we recommend a dosage range. We apply the following auxiliary label to cassette for nursing staff: **“Please start with the lowest infusion rate & bolus indicated. May titrate basal rate up IN SMALL INCREMENTS when excessive boluses required in previous 24-hour period.”**	**DEFAULT CONCENTRATION** (Others available upon request)
	☐ **Hydromorphone Subcutaneous**	☐ (0.1mg to 1mg/hr range): ______ **to** ______ **mg/hr** ☐ **PRN only**	1mg/mL
		☐ (0.5mg to 5mg/hr range): ______ **to** ______ **mg/hr**	5mg/mL
		☐ (1mg to 10mg/hr range): ______ **to** ______ **mg/hr**	10mg/mL
		☐ (10mg to 20mg/hr range): ______ **to** ______ **mg/hr**	20mg/mL
	☐ **Morphine Subcutaneous**	☐ (0.5mg to 5mg/hr range): ______ **to** ______ **mg/hr**	5mg/mL
		☐ (5mg to 20mg/hr range): ______ **to** ______ **mg/hr**	20mg/mL
		☐ (20mg to 40mg/hr range): ______ **to** ______ **mg/hr**	40mg/mL
	☐ **Other Subcutaneous**	Specify:______ ☐Add 4mg of Dexamethasone to each cassette (for site irritation)	
►	**BOLUS* Subcutaneous**	_______ **mg to** ______ **mg q.30 minutes PRN (HALF OF BASAL)**	
►	**Total Quantity Authorized:** ☐ **5** ☐ **10 x 100mL Cassettes** or ☐ **Other Quantity:** ____________________ **To be dispensed 1 cassette no earlier than q.4 days** (considering variables of concentration and bolus frequency)		

☐ CHANGE ABOVE ORDER TO **PICC LINE** Infusion with conversion of appropriate concentration to 250mL bags
(ONLY exceptional cases when subcutaneous site is no longer an option)

ADDITIONAL MEDICATION ORDER: Drug:______________________________________ **Concentration:**_______**mg/mL**
Route: ☐ **Subcutaneous** ☐ **Peripheral** ☐ **Central** **Infusion Rate:**_____________**mg/hr** **Bolus:**________**mg/**___________**min**
Total Quantity: _____ **x100mL Release: 1 cassette q.** ______ **days** (Note Stability: Ketamine: 7 days, Midazolam: 10days).

Flush Instructions: ☐ Local Nursing Provider protocol unless otherwise specified
☐ Other (Specify): ______

Site Care: ☐ As per Best Practice Guidelines (e.g. Canadian Vascular Access Association; Registered Nurses’ Association of Ontario). ☐ Other (Specify): ______
Next dressing change due(DD/MM/YYYY):
Note: Radiologic Report confirming PICC line placement must accompany referral

Please note that in rural areas a <u>48 hour turnaround time</u> may be required. Patients must return to primary care practitioner or local outpatient services to receive therapy or be maintained on alternate route until medication/equipment-supplies are available.
As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

____________________	____________	____________________	____________________
Physician Name	CPSO#	Physician Signature	Date (DD/MM/YYYY)

Community Pharmacist: ______________________________ Date (DD/MM/YYYY): ______________________

Offices: **Toll Free Tel: 1 800 461 2919** Website: http://healthcareathome.ca/northeast/en

☐ **KIRKLAND LAKE**	☐ **NORTH BAY**	☐ **PARRY SOUND**	☐ **SAULT STE. MARIE**	☐ **SUDBURY**	☐ **TIMMINS**
Fax: 705 567 9407	Fax: 705 474 0080	Fax: 1 855 773 4056	Fax: 705 949 1663	Fax: 705 522 3855	Fax: 705 360 5554