NSM Common Palliative Referral
GUIDELINES FOR COMPLETION

Field	Content
Patient Demographics	
Name	Enter patient's surname and first name
HCN	Enter the patient's HCN
VER	Enter the patient's HCN version code if applicable
Client #	Enter patient's CHRIS client number
BRN	Enter patient's CHRIS BRN number
DOB (yyyy/mm/dd)	Enter patient's date of birth
HCCSS Care Coordinator	Enter Care Coordinator's name (if known)
Referring Physician	Enter referring physicians name, phone number and fax number
Date of Referral	Enter referral date
Application Checklist	Include if available/applicable: Recent Consultation Notes, Communication to the individual's family physician of referral for palliative care services, Copy of completed Do Not Resuscitate Confirmation Form
Medical Orders Attached	Check if medical orders attached
Type(s) of Services Requested	
Community Palliative Care Providers Services	Check if appropriate and select appropriate referral
Community Hospice Services	Check if appropriate and enter details
Medical Assistance in Dying (MAiD)	Check if appropriate and select appropriate option
Home and Community Care Support Services NSM	Check if appropriate and select all appropriate services
Pain and Symptom Management	Check if appropriate
Hospice Residence	Check and select appropriate hospice residence; if other is selected, specify agency name
For HCCSS Care Coordinator Only	This section is to be completed by HCCSS CC • In the event that 911 is called and an alternate destination is an option, select a hospice that the patient has consented to attend for treatment • Select yes/no for EDITH form in home • Select yes/no for SRK in home
Urgency of Response	Check appropriate option
Patient Information	
Home Address	Enter patient's home address (street, apt #, city, postal code)
Living arrangements	Check appropriate checkboxes; if there are pets in the home, please specify
Phone Numbers	Enter patients home and alternate numbers
Gender	Check appropriate option; if other, please specify
Faith/Religion	Enter patient's faith
Language(s)	Enter patient's language If translator is used, enter name and phone number
Patient Identifies as	Check appropriate option; if other, please specify
Current location	Check appropriate option; if other, please specify
Hospital	Check if appropriate Enter name of hospital and estimated discharge date
Primary Palliative Diagnosis	Enter primary palliative diagnosis and date of diagnosis If Cancer diagnosis – check appropriate option and enter details
Individual aware of	Select appropriate option for diagnosis and prognosis
Family aware of	Select appropriate option for diagnosis and prognosis If family is not aware, select appropriate option for consent to inform family

Field	Content
Anticipated prognosis	Check appropriate option Enter the name and phone number of person who determined anticipated prognosis
Functional Status	Check appropriate option
Resuscitation Status	• Check if appropriate • Discussed with - select appropriate option
Family/Informal Caregivers: Provide Power of Attorney for Personal Care	Enter family/informal caregiver's name, relationship, home and business/cell phone numbers
List all Providers and Services Currently Involved	Enter name, phone and fax numbers for: • Family physician • Community nursing • Hospice • other
Co-Morbidities	• Check if documentation is attached • Enter year and diagnosis
Infection Control	Check appropriate option If referring from acute care facility, attach available reports from within the last 2 weeks and include treatment provided
Allergies	Check appropriate option; if yes, list the allergies
Pharmacy	Enter name and number of pharmacy
Current medication	• Check if list is attached • Enter drug, dose, route, and interval
Details of Social Situation, Including any Needs/Concerns of family	Enter details as appropriate
Special Care Needs	Check all that apply; specify details if drains/catheter, wound care, therapeutic surface or other needs is selected. If patient is on oxygen, provide the rate
Symptom assessment	• Provide an ESAS score for pain, tiredness, nausea, depression, drowsiness, appetite, well-being, shortness of breath and anxiety. If other, provide both details and score • Provide date ESAS completed • Provide insurance information
Any additional Information	Provide additional information as appropriate
Form completed by	Enter the name, phone and fax numbers and professional designation of person completing the form