

**Palliative Patient Registry Referral Form**

Fax completed form to: 416 222-6517 / 905 952-2404

**This form is not intended to communicate urgent health care needs. If you are referring a patient for urgent Home and Community Care Support Services, please complete a Medical Referral Form.**

Home and Community Care Support Services Central Palliative Patient Registry supports patients who benefit from a palliative approach to care. Suitable patients are those who are in the end stage of a life limiting illness.

Once admitted to the Palliative Patient Registry, individuals will be regularly assessed, supported and linked to palliative resources by a Home and Community Care Support Services Central Care Coordinator.

**PATIENT INFORMATION**

(Last Name, First Name) \_\_\_\_\_

Home Address: \_\_\_\_\_ DOB (dd-mmm-yyyy): \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Health Card Number and Version Code: \_\_\_\_\_ Gender:  Male  Female

Primary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Co-Morbidities: \_\_\_\_\_

Has Advanced Care Plan been discussed?  Yes  No

Is there a DNR in place?  Yes  No

Estimated life expectancy 12 months or less?  
 Yes – Proceed to complete rest of the form  No – Do not refer to registry at this time

Palliative Performance Scale (PPS) Score:  
 10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

**Please check off general indicators of decline:**

<input type="checkbox"/>	Advancing disease – unstable, deteriorating complex symptom burden	<input type="checkbox"/>	Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
<input type="checkbox"/>	Decreasing response to treatments, decreasing reversibility	<input type="checkbox"/>	Weight loss greater than 10% in past six months
<input type="checkbox"/>	Choice of no further disease modifying treatment	<input type="checkbox"/>	Repeated unplanned/crisis hospital admissions
<input type="checkbox"/>	General physical decline	<input type="checkbox"/>	Sentinel event, e.g. serious fall, bereavement, retirement on medical grounds
<input type="checkbox"/>	Declining functional performance status, i.e. PPS less than or equal to 60%, reduced ambulation, increasing dependence in most activities of daily living	<input type="checkbox"/>	Serum albumin Less than 25 g/L

**Palliative Patient Registry Referral Form**

(Patient Last Name, First Name)

Health Card Number and Version Code:

**Please check off specific clinical indicators of End Stage Disease:**

CANCER	LUNG DISEASE (COPD)	HEART DISEASE (CHF)
<input type="checkbox"/> Metastatic disease <input type="checkbox"/> Spending more than 50% of time in bed/lying down	<input type="checkbox"/> Disease assessed to be very severe (FEV1 less than 30% predicted) <input type="checkbox"/> Recurrent hospital admissions (more than 3 in the last 12 months due to COPD) <input type="checkbox"/> Dyspnea after 100 m on the level <input type="checkbox"/> Signs and symptoms of right heart failure <input type="checkbox"/> More than 6 weeks of systemic steroids for COPD in preceding 6 months	<input type="checkbox"/> Stage 3 or 4 <input type="checkbox"/> Shortness of breath on minimal exertion <input type="checkbox"/> Difficult physical or psychological symptoms despite optimal tolerated therapy
RENAL DISEASE	NEUROLOGICAL DISEASE	DEMENTIA
<input type="checkbox"/> Stage 4 or 5 <input type="checkbox"/> No dialysis or discontinuing dialysis <input type="checkbox"/> Difficult physical or psychological symptoms <input type="checkbox"/> Symptomatic – nausea, vomiting, anorexia, pruritus, reduce functional status, intractable fluid overload	<input type="checkbox"/> Symptoms which are too complex or too difficult to control <input type="checkbox"/> Swallowing problems with recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure <input type="checkbox"/> Speech problems <input type="checkbox"/> Communication problems <input type="checkbox"/> Cognitive decline <input type="checkbox"/> Marked rapid decline in physical status <input type="checkbox"/> Weight loss <input type="checkbox"/> Low vital capacity (below 70% via spirometer)	<input type="checkbox"/> Unable to walk without assistance <input type="checkbox"/> Urinary and fecal incontinence <input type="checkbox"/> No meaningful verbal communication <input type="checkbox"/> Weight loss <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Pressure sores <input type="checkbox"/> Reduced oral intake <input type="checkbox"/> Aspiration pneumonia

**Please check off palliative resources you are suggesting:**

<input type="checkbox"/> Caregiver Support <input type="checkbox"/> Day Hospice <input type="checkbox"/> End-of-Life Planning <input type="checkbox"/> Hospice Volunteer <input type="checkbox"/> Hospice Palliative Care (Advanced Practice Nurse)	<input type="checkbox"/> Medication Management <input type="checkbox"/> Palliative Physician <input type="checkbox"/> Support Group <input type="checkbox"/> Transportation to Appointments <input type="checkbox"/> Visiting Hospice Program	Non-Urgent Services: <input type="checkbox"/> Home Safety Assessment <input type="checkbox"/> Palliative Nurse Practitioner <input type="checkbox"/> Personal Support <input type="checkbox"/> Visiting Nursing
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**Comments:**

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Professional Designation:** \_\_\_\_\_ (dd-mmm-yyyy)

**Organization:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**If you have any questions, please call 905 895-1240 or 416 222-2241 ext. 5562**