TO ALL PALLIATIVE CARE PROVIDERS

(For the purpose of this Form, an individual refers to a patient or client)

Your submission of this form will be taken to explicitly mean that you have gained appropriate permission for release of the information contained to the agencies and services to whom you are submitting this. Please also include your Organization's Release of Information Form, if applicable.

Please complete this form as thoroughly as possible and PRINT clearly. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section.

Individual's Last Name: **First Name:**

Goals of Care/ Reason for Referral:

Application Checklist (include if available):

☐ Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)

☐ Communication to the individual's family physician of referral for palliative care services

☐ Copy of completed Do Not Resuscitate Confirmation Form

☐ Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) ☐ Recent chest x-ray

☐ Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.**

☐ Recent consultation notes ☐ Recent laboratory results ☐ Pathology reports

Note: Referral Source must be responsible to send referral to all services requested as indicated above; If urgency request is within 1-2 days, a phone contact must be made to the service request

Type(s) of services requested	Urgency of response	Pages Required
☐ **Community Care Access Centre** (complete CCAC Medical Referral Form):	☐ 1-2 days ☐ 1 - 2 weeks	**Page 1-4**
☐ **Community Palliative Care Physician** (Specify Palliative Physician Team): Referral is for: ☐ Consultative care ☐ Primary care	☐ 1-2 days ☐ 1 - 2 weeks	**Page 1-3**
☐ **Hospice Program**: ☐ **Home Visiting** ☐ **Day Program** ☐ **Residential Hospice** (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future ☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**
☐ **Inpatient Palliative Care Unit** (List all units referred):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**
☐ **Other** (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**

[1] The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered.

Individual's First & Last Name:

Home Address:_____**Apt#**____ **Entry Code** _____**Postal Code**_____

☐ Lives Alone ☐ Young Children in the Home ☐ Smoking in the Home ☐ Pet in the Home *(specify):* ____

Home phone number: _____ **Alternate number:** _____

Date of birth: *(DD/MM/YY)* _____ **Gender:** ____ **Faith/Religion:** _____

Health card number: _____ **Version code:** _____

Primary language(s): _____ **Translator:** *(name/phone #):* _____

Current location: ☐ Home ☐ Residential hospice ☐ Other *(specify address):* _____

☐ Hospital _____ Anticipated hospital discharge date: _____

Primary palliative diagnosis: _____ **Date of Diagnosis** _____

Other relevant diagnosis/symptoms:

If cancer diagnosis: metastatic spread: ☐ Yes ☐ No Describe: _____

If cancer diagnosis: ongoing treatment: ☐ Yes ☐ No Describe: _____

Individual aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

Family are aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

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

Anticipated prognosis: ☐< 1 month ☐< 3 months ☐< 6 months ☐< 12 months ☐Uncertain
Determined by *(name and phone number)*: _____

Functional status: *Palliative Performance Scale (PPS): refer FAQs for more details*
PPS: ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Resuscitation status: Do Not Resuscitate ☐ Yes ☐ No Unknown ☐
Discussed with: Individual ☐ Yes ☐ No Family ☐ Yes ☐No

Family/Informal Caregivers: Provide Power Of Attorney for Personal Care if known:

Name	Relationship	Home Phone	Business/Cell Phone

Please list all Providers and Services currently involved*:* (if Known) ☐ Additional list attached

Name	*Phone*	*Fax*
Family Physician:		
CCAC		
Community Nursing		
Hospice		
Other		

Individual's First & Last Name:

Co-Morbidities: ☐ **Check here if documentation is attached**

Year	Diagnosis	Year	Diagnosis

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(specify precaution)*: _____

Allergies: ☐ Yes ☐ No ☐ Unknown ☐ If Yes (please specify): _____

Pharmacy (name and number) If Known: _____

Current medications: ☐ **medication list attached**

(Include complementary alternative medications and over-the-counter medications)

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Details of social situation, including any needs/concerns of the family:

Individual's First & Last Name:

Special care needs: _____ (please check all that apply)

☐ Transfusion ☐ Hydration: ☐ SC or ☐ IV ☐ Infusion pump(s) ☐ Total Parental Nutrition ☐ Enteral feeds

☐ Dialysis ☐ Central line(s) ☐ P.I.C.C. line(s) ☐ PortaCath ☐ Tracheostomy

☐ Oxygen: rate: _____ ☐ Thoracentesis ☐ Paracentesis ☐ Drains/Catheter *(specify)*: _____

☐ Ostomy care ☐ Urinary catheter

☐ Wound care *(specify):* _____

☐ Therapeutic surface *(specify):* _____

☐ Other needs: _____

Symptom assessment:

ESAS Score at the time of referral: *(Adapted from Edmonton Symptom Assessment System—ESAS, Capital Health, Edmonton)*
(rate symptoms: 0 = no symptom, 10 = worst symptom possible – See FAQs for details):

Pain ___ Tiredness ___ Nausea ___ Depression ___ Anxiety ___ Drowsiness ___

Appetite ___ Well-being ___ Shortness of breath ___ Other: ___

Date ESAS completed: _____

Insurance Information: _____

Has expressed willingness to pay for private services: ☐ Yes ☐ No ☐ Not Known

For inpatient palliative care units: ☐ Private accommodation requested

Any additional information:

Individual Completing Form: _____ **Tel:** _____ **Fax:** _____
(Referring) Physician: _____ **Tel:** _____ **Fax:** _____

Date of Referral: *(DD/MM/YY)* _____