The Dorothy Ley Hospice
A COMMUNITY OF SUPPORT & CARE

Bereavement & Spiritual Care
Common Referral Form
For Palliative Individuals, their Families and Caregivers

Referral Made By: *(Please provide full contact information)*

Name: _____ **Agency/Role:** _____

Phone: _____ **Email:** _____

Referral For: *(Please provide full contact information)*

Name: _____ **DOB:** _____/_____/_____ (mm / dd / yyyy)

Address: _____ (Street) _____ (Suite or Room #)

City: _____ **Postal Code:** _____

Phone: ( ) _____ - _____ **(H)** ( ) _____ - _____ **(C)**

Primary Language: _____ **Faith/Religion:** _____

Alternative Contact: *(Check if this is the primary person to contact)*

☐ **Name:** _____ **Relationship:** _____

Phone: ( ) _____ - _____ **(H)** ( ) _____ - _____ **(C)**

Situational Information:

☐ ***Individual is living with life-limiting illness*** PPS: _____ % (if available)

Diagnosis: _____ Prognosis: ☐ < 1 mos ☐ 1-3 ☐ 3-6 ☐ 6-12

Individual is currently: ☐ At Home ☐ In Hospital, _____ (Specify)

☐ In LTC, _____ (Specify)
(Name of facility and Street Address) (Suite or Room #)

Individual requires: ☐ 1-1 Spiritual/Emotional Support ☐ Living with Illness Support Group
☐ In-home visits ☐ Transportation services to access community support

☐ ***Individual is family caregiver*** and requires: ☐ 1-1 Spiritual/Emotional/Anticipatory Grief Support
☐ Caregiver Support Group

☐ ***Individual is bereaved*** and requires: ☐ 1-1 Bereavement Support ☐ Grief Support Group

Deceased : _____ (Full Name) Relationship: _____

Date of Death: _____/_____/_____ (mm / dd / yyyy) Circumstances: _____

Continue on reverse side

Forward to The Dorothy Ley Hospice
Fax: 416-626-7285 *(Preferred)* **Inquires Call: 416-626-0116 x 225**

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Name: _____ **DOB:** _____/_____/_____
(mm / dd / yyyy)

Agencies currently involved: ***(specify)***

☐ **CCAC** ☐ **Wellspring** ☐ **Faith Community** ☐ **Hospice** _____

☐ **Other** _____ ☐ **Other** _____

Additional Comments:

_____

_____

_____

_____

_____

_____

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