Referral Form to the Dorothy Ley Hospice (DLH) Community Physicians

220 Sherway Drive, Etobicoke, ON, M9C 0A7, Tel: 416-626-2138

Please fax referral form and supporting medical documents to 647-689-5880

Your submission of this form will be taken to explicitly mean that the patient has given their permission to make the referral and to disclose appropriate personal health information for initiating the services of our palliative care physicians.

Referral eligibility:

□ patient has prognosis of less than 1 year with PPS ≤ 60% □ patient is receiving LHIN services (if not, please initiate) □ patient lives in catchment area (refer to the map) □ referral is NOT solely for MAiD provision	□ referral source (or GP) remains MRP until patient is seen and accepted by DLH Community Physicians □ referral source (or GP) agrees to resume MRP status if patient improves and no longer meets referral criteria □ all physicians agree to stop billing G512 code once patient accepted to DLH Community Physician team

Date of Referral:	

Last Name	**First Name**

Reasons for Referral / Goals of Care (if known):

Reasons for Referral:	**Urgency**
□ Shared care (details to be discussed between the Family MD and the palliative MD)	□ urgent (within 5 business days) □ semi-urgent (within 10 business days) □ non-urgent (within 20 business days)
□ Transfer of care to Dorothy Ley Community Physicians (PPS ≤ 60%)	□ urgent (within 5 business days) □ semi-urgent (within 10 business days) □ non-urgent (within 20 business days)
□ Referral to the Dorothy Ley Community Support Program (psychosocial support, caregiver support)	□ urgent (within 5 business days) □ semi-urgent (within 10 business days) □ non-urgent (within 20 business days)

Patient Information

Date of Birth (dd/mm/yyyy) ____ / ____ / _______	Health Card Number			VC
Address	Apt#	City	Entry code	Postal Code

Current location:
□Home □Retirement Home □Hospital_________________________ Anticipated discharge date ________

□Lives alone □Young children in the home □Smoking in the home □Pets in the home______________

Telephone (Home) ____________________ (Alternate number) ____________________

Primary Palliative Diagnosis:	
If cancer diagnosis	**Metastatic spread:** □Yes □No Describe:

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	Ongoing treatment: □Yes □No Describe:
Other relevant diagnosis/ distressing symptoms	
Palliative Performance Scale (PPS)	□10% □20% □30% □40% □50% □60% □70% □80% □90% □100%
Anticipated Prognosis	□<1month □<3months □<6months □<12months □Uncertain Determined by ______________________________
Resuscitation Status	Do Not Resuscitate: □ Yes □ No □ Unknown Discussed with: Individual: □ Yes □ No Family: □ Yes □ No

Providers and Services Involved

	Name	Phone	Fax
Family physician			
CCAC			
Community nursing			
Hospice			
Other			

Family/Informal Caregivers

Power Of Attorney for Personal Care:______________________________

Name	Relationship	Home phone	Alternate phone

Past Medical History:

Diagnosis	Year	Diagnosis	Year

Allergies (if known): □Yes □No □Unknown
If yes, specify ______________________________

Infection control	□ MRSA/VRE (+) □ C-Diff (+) □ ESBL □ Other, specify
Symptom Management Kit in the home	□ yes □ no □ not known

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Additional information (Details of social situation, equipment needs, and needs/concerns of the family)			
Referring organization			
Individual completing form	**Name:**	**Phone:**	**Fax:**
Referring physician	**Name:**	**Phone:**	**Fax:**

For further information about our referral process, eligibility criteria, or general inquiries, please contact us at 416-626-0116 x 233.