Dorothy Ley Hospice

Palliative Care Referral to the Dorothy Ley Community Physicians Ambulatory Clinic

(220 Sherway Drive Toronto, ON M9C 0A7- 416.626.0116 ext. 225)

Date of Referral:	

Patient Information				
Last Name		First Name		
Date of Birth (dd/mm/yyyy)				
Address	Apt#	City	Prov.	Postal Code
Home Telephone	Health Insurance Number			VC:

Primary Palliative Diagnosis:	
Relevant Co-morbidities	
Reason for Referral	☐ One time consult only for pain and symptom management (must be accompanied by recent/relevant patient history /consultation reports and medication list) ☐ Shared care (details to be discussed between the Family MD and the palliative care MD) ☐ Transfer of care to Dorothy Ley Hospice Community Physicians (PPS ≤ 50%) ☐ Referral to the Dorothy Ley Community Support Team

Does your patient currently have home and community care services? ❑**Yes** ❑ **No**

Referring Family Physician **Billing number:**	**Phone-** **Fax-**

The individual medical doctors of our group have decided to abstain from providing medical assistance in dying (MAID). Therefore, we cannot accept referrals for patients STRICTLY seeking MAID.

FAX COMPLETED FORM TO: 647.689.5880