

Palliative Care Referral Form



TO ALL PALLIATIVE CARE PROVIDERS (For the purpose of this Form, an individual refers to a patient and/or client)

Please complete this form¹ as thoroughly as possible. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section. Please ensure that the prescriber's signature is included where orders are given on page 6.

The CCAC "placement application form" no longer needs to accompany the Common Referral Form.

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.

If this is being used to refer to a palliative care inpatient facility

When the individual is ready for transfer to a palliative care facility, please contact the unit directly. Include the most recent clinical update and medication list and identify any special needs such as special mattresses or other surfaces required, nephrostomy tubes, chest tubes, intravenous access devices or infusion pumps, etc. in the transfer information package (refer to Page 3). Please note that **resuscitation is not offered** as part of the admission criteria for in-patient palliative care and residential hospice care. Definition of Cardiopulmonary Resuscitation (CPR) by Ministry of Health and Long-Term Care (MOHLTC) - is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardiorespiratory arrest. These measures include basic cardiac life support involving chest compressions, and/or artificial ventilation e.g. mouth-to-mouth resuscitation, bagging, and where available, defibrillation, intubation and other procedures considered to be Advanced Cardiac Life Support procedures by the Heart and Stroke Foundation of Ontario.

Application Checklist (include if available):

- Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **Reports must be current at time of referral and within the last 2 weeks as available. (If referring from acute care facility, this information must be included.)**
- Recent consultation notes
- Recent laboratory results
- Pathology reports
- Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) Most recent chest x-ray
- Care protocols attached e.g. wound care, central line care

Referral Source:

Name & Discipline: _____ **Tel.:** _____ **Fax:** _____

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

Date of referral: (DD/MM/YY) _____ **Date of birth:** (DD/MM/YY) _____ **Gender:** _____

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

Primary language(s): _____ **Faith/Religion:** _____

Current location: Home Residential hospice Other (Specify address): _____
 Hospital _____ Anticipated hospital discharge date: _____

Home location: (Address) _____ **Postal code:** _____

Home phone number: () _____ - _____ **Alternate number:** () _____ - _____

Pet in the Home (specify): _____ Lives Alone Smoking in the Home

Primary palliative diagnosis: _____

Metastatic spread, if malignant: _____

Reason for referral: Symptom management (specify): _____
 Psychosocial Support
 Respite/Support for caregiver
 Assessment for Services Activities Daily Living Instrumental A.D.L. (eg. Shopping, banking)
 Individual does not wish to die at home Other (specify) _____

Individual's goals of care: _____

Anticipated prognosis: < 1 month < 3 months < 6 months < 12 months Uncertain
 Determined by: _____

For CCAC purposes, is death anticipated within the next 6 – 12 months? Yes No

Individual aware of: Diagnosis Prognosis Does not wish to know

Family are aware of: Diagnosis Prognosis Does not wish to know

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

Resuscitation status: Do Not Resuscitate Resuscitate (**Note: If this box is checked, individual is NOT eligible for PCU and Residential Hospice**)
 Do Not Resuscitate Confirmation Form Completed

Substitute Decision Maker:

	Name	Home Phone	Business/Cell Phone
Power of Attorney (POA) for Personal Care <input type="checkbox"/> Documentation attached			
If no POA, substitute decision maker according to the legislated hierarchy			

Advance Care Directive in place should individual be incapable as per Health Care Consent Act 1996²: Yes No
Documentation attached: Yes No

Type(s) of services requested	Urgency of response	List all placement referrals made: 1) 2) 3)
<input type="checkbox"/> Inpatient Palliative Care Unit	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Residential Hospice	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Home hospice Program	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Day Hospice Program	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Community visiting (e.g. Interlink nurse, physician team, etc.) – LIST SERVICE REQUESTED:	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> CCAC	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Palliative Pain/Symptom Management Consultant (PPSMC)	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Palliative Care Community Team	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	

² The Health Care Consent Act 1996, c. 2, Sched. A, s. 4 (1).states "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision". Page 2 of 6

Individual's Last Name: _____ First Name: _____

Please list all Providers currently involved:

Name	Phone	Fax
<input type="checkbox"/> Additional list attached		

Symptom assessment

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

Date completed: _____

Pain _____ Tiredness _____ Nausea _____ Depression _____ Anxiety _____ Drowsiness _____

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

Bowel function: Constipation: Yes No Last normal BM: _____ Diarrhea: Yes No Frequency: _____

Bladder function: Continent Incontinent Catheter

Symptom(s) most distressing to the individual:

Current Care needs: (please check all that apply)

- Transfusion: Hydration: SC or IV Enteral feeds Central line(s) P.I.C.C. line(s) PortaCath
- Dialysis Oxygen Chest tube(s) Thoracentesis Paracentesis
- Feeding tube Infusion pump(s) Pressure ulcer(s) Ostomy care Tracheostomy

Wound care (specify): _____

Therapeutic surface (specify): _____

Other needs: _____

Special needs: MRSA/VRE (+) C-DIFF (+) Other (specify precaution): _____

Symptom Management Kit in the home? Yes No Not Known

Prior treatment for diagnosis? Radiotherapy Date: _____ Chemotherapy Date: _____

Surgery Date: _____ Other: _____ Date: _____

Ongoing treatment for diagnosis? Radiotherapy Surgery Chemotherapy: Last treatment date: _____

Other: _____

Does the individual have a Family Physician/General Practitioner? Yes No

If Yes, Contact Information: _____

Will this Provider make home visits? Yes No

Health History: (please attach a printout if available) Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis



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

Present medications: Check here if additional medication documentation is attached

(Include complementary alternative medications and over the counter medications)

Drug	Dose	Route	Interval

Allergies: None known Present (please specify) _____

Approximate Height: _____ Approximate Weight: _____

Functional status: Palliative Performance Scale (PPS) at time of referral (refer to Victoria Hospice Society, PPSv2/ Cancer Care Ontario for definition). 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Mobility: Ambulatory Ambulatory with aid Ambulatory with people Bed-ridden

Cognition: Alert Altered Cognition Responsive to Stimuli Unresponsive

Bathing: Independent With assistance Total assist

Feeding: Independent With assistance Total assist NPO

Difficulty swallowing (describe): _____

Diet Type: _____ Diet Texture: _____ Other: _____

Other: Vision impaired Hearing impaired Speech impaired

Behaviour (describe): _____

Family/Informal Caregivers:

Name	Relationship	Name	Relationship

Psychosocial and Spiritual status and concerns:

Issue	Yes	No	Unknown	Description
Spiritual Distress				
Financial Concerns				
Family Issues				
Past Substance Use				
Current Substance Use				
Other				

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

Insurance information (if known): _____

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

For inpatient palliative care units:

Semi-private accommodation requested Private accommodation requested Co-payment fees reviewed (where appropriate)

Details of social situation:

Any additional information appropriate:

Form completed by (print/signature): _____ **Date:** _____

Telephone and pager number (if different from referral source): _____



Individual's Last Name: _____ First Name: _____

**PLEASE COMPLETE THIS SECTION OF THE FORM FOR ANY REFERRAL TO CCAC
AND INCLUDE PAGES 1-5 WITH THIS REFERRAL**

(Treatments will be taught/reduced unless otherwise indicated)

Service requested:		Prescriber's Orders:
Nursing	<input type="checkbox"/>	
Dietician	<input type="checkbox"/>	
Occupational therapy	<input type="checkbox"/>	
Personal support	<input type="checkbox"/>	
Physiotherapy	<input type="checkbox"/>	
Social work	<input type="checkbox"/>	
Speech therapy	<input type="checkbox"/>	
Laboratory tests (Where Applicable)	<input type="checkbox"/>	Type(s) and frequency: _____ _____
		Report results to: _____
		Start date: _____ / _____ / _____
Other (specify): _____	<input type="checkbox"/>	

Signature of Prescriber: _____ Designation: _____

Medical Supervision while on CCAC services

Referring Physician (Attending): _____	Most Responsible Physician: _____ <input type="checkbox"/> Check if same as Attending Physician
Staff physician's name (if applicable):	Name:
Name:	Address:
Address:	Office phone number:
Phone number:	After hours phone number:
Specialty:	Fax number:
OHIP billing code:	Specialty:
Signature:	OHIP billing code:
Signature date:	Has this physician been contacted and agrees: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Contacted by:
	Date of contact:
	Date of next medical appointment: