Ontario Health atHome

REFERRAL FOR PALLIATIVE/END-OF-LIFE SERVICES

Patient Details and Demographics

Health Card Number:	Version Code:	Date of Birth (DD/MM/YYYY):	
Surname:	First name(s):		
Address:	City:	Province:	Postal Code:
Phone #:	Alternate Phone #:	Primary Language: ☐English ☐French ☐Other	
Gender: ☐Male ☐Female ☐ Unidentified ☐ Unknown			
Name of Contact Person (if other than Patient):		Phone #:	
Relationship: ☐POA/SDM ☐Spouse ☐Other (specify):		Alternate Phone #:	

Health Information

Relevant diagnosis:	Reason for Referral:
☐**In home pronouncement** ☐DNR in place ☐Patient/Family aware of diagnosis ☐End of Life Palliative Performance Score:	
Infection control: ☐MRSA Positive ☐VRE Positive ☐C diff ☐TB ☐Other:	Allergies:

Services Requested

☐Nursing ☐Personal Support ☐Physiotherapy ☐Occupational Therapy ☐Social Work ☐Speech Language Pathology ☐Nutrition

☐Nurse Practitioner Palliative Care *Sudbury, West Nipissing, Sault Ste. Marie, Timmins & District of Temiskaming only

☐Assess for Alternate Programs: ☐Hospice *Sudbury, Sault Ste. Marie ☐Complex Continuing Care ☐LTC/Short-Stay Respite

Previous Opioid Medication needed in last 24-hour period (oral conversion to subcutaneous): _____

	DRUG	BASAL INFUSION RATE: For optimum management, we recommend a dosage range. We apply the following auxiliary label to cassette for nursing staff: **"Please start with the lowest infusion rate & bolus indicated. May titrate basal rate up IN SMALL INCREMENTS when excessive boluses required in previous 24-hour period."**	DEFAULT CONCENTRATION (Others available upon request)
►	☐ **Hydromorphone Subcutaneous**	☐ (0.1mg to 1mg/hr range): _____ **to** _____ **mg/hr** ☐ **PRN only**	1mg/mL
		☐ (0.5mg to 5mg/hr range): _____ **to** _____ **mg/hr**	5mg/mL
		☐ (1mg to 10mg/hr range): _____ **to** _____ **mg/hr**	10mg/mL
		☐ (10mg to 20mg/hr range): _____ **to** _____ **mg/hr**	20mg/mL
	☐ **Morphine Subcutaneous**	☐ (0.5mg to 5mg/hr range): _____ **to** _____ **mg/hr**	5mg/mL
		☐ (5mg to 20mg/hr range): _____ **to** _____ **mg/hr**	20mg/mL
		☐ (20mg to 40mg/hr range): _____ **to** _____ **mg/hr**	40mg/mL
	☐ **Other Subcutaneous**	Specify**:**_____ ☐Add 4mg of Dexamethasone to each cassette (for site irritation)	
►	**BOLUS* Subcutaneous** _____ **mg to** _____ **mg q.30 minutes PRN (HALF OF BASAL)**		
►	**Total Quantity Authorized:** ☐ **5** ☐ **10 x 100mL Cassettes** or ☐ **Other Quantity:** _____ **To be dispensed 1 cassette no earlier than q.4 days** (considering variables of concentration and bolus frequency)		

☐ CHANGE ABOVE ORDER TO **PICC LINE** Infusion with conversion of appropriate concentration to 250mL bags
(ONLY exceptional cases when subcutaneous site is no longer an option)

ADDITIONAL MEDICATION ORDER: Drug:_____ **Concentration:**_____**mg/mL**
Route: ☐ **Subcutaneous** ☐ **Peripheral** ☐ **Central** **Infusion Rate:**_____**mg/hr** **Bolus:**_____**mg/**_____**min**
Total Quantity: _____**x100mL Release: 1 cassette q.** _____ **days** (Note Stability: Ketamine: 7 days, Midazolam: 10days).

Flush Instructions: ☐ Local Nursing Provider protocol unless otherwise specified
☐ Other (Specify): _____

Site Care: ☐ As per Best Practice Guidelines (e.g. Canadian Vascular Access Association; Registered Nurses' Association of Ontario). ☐ Other (Specify): _____
Next dressing change due(DD/MM/YYYY)**:**
Note: Radiologic Report confirming PICC line placement must accompany referral

Please note that in rural areas a 48 hour turnaround time may be required. Patients must return to primary care practitioner or local outpatient services to receive therapy or be maintained on alternate route until medication/equipment-supplies are available.
As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

Physician Name	CPSO#	Physician Signature	Date (DD/MM/YYYY)

Community Pharmacist: _____ Date (DD/MM/YYYY): _____

Offices: **Toll Free Tel: 1 800 461 2919** Website: http://healthcareathome.ca/northeast/en

☐ **KIRKLAND LAKE**	☐ **NORTH BAY**	☐ **PARRY SOUND**	☐ **SAULT STE. MARIE**	☐ **SUDBURY**	☐ **TIMMINS**
Fax: 705 567 9407	Fax: 705 474 0080	Fax: 1 855 773 4056	Fax: 705 949 1663	Fax: 705 522 3855	Fax: 705 360 5554