

Margaret's Place
Fax to: 905-627-6577

Patient Information	BRN # _____
Patient Name _____ HCN _____ VC _____ DOB _____	
Address _____ City _____ Province _____ Postal Code _____	
Patient Phone # _____ Current Location _____	
SDM _____ Relationship _____ Phone _____	
Preferred Language _____ Gender Identify _____	
Care Coordinator _____ Phone _____ Ext. _____	
Overnight Respite Services Requested (Estimated LOS 2-14 days)	
<input type="checkbox"/> Respite Stay Start Date _____ End Date _____	
<input type="checkbox"/> Stabilization of Exacerbation of life-limiting illness Describe: _____	
Primary Community Health Care Provider Information	
Community MRP Name _____ MRP aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MRP Phone _____ Backline or Cell _____ Fax _____	
Primary Specialist _____ Phone _____ Fax _____	
Medical Information	
Primary Diagnosis _____ Date of Onset _____ PPS _____	
Secondary Diagnosis / Comorbidities _____	
Allergies _____	
Symptoms Requiring Management (nausea, pain, etc.) _____	
Patient & Family's Goals & Expectations _____	
Other Relevant Information _____	
COVID-19 Vaccination Status: <input type="checkbox"/> Fully Vaccinated <input type="checkbox"/> Partially Vaccinated <input type="checkbox"/> Unknown or Not Vaccinated	
History of MRSA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown VRE: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown C-Diff: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Attachments: <input type="checkbox"/> Medical Summary / Health History <input type="checkbox"/> Consult / Progress Notes <input type="checkbox"/> Other Notes	
<input type="checkbox"/> Pertinent Diagnostic Tests <input type="checkbox"/> Current Medication List	
<input type="checkbox"/> Pharmacy _____	
<input type="checkbox"/> Referral Eligibility for Overnight Respite Services Confirmed by Care Coordinator	
Care Coordinator _____ Date _____ Phone _____	

Margaret's Place - Palliative Overnight Respite Referral Form

Eligibility for end-of-life respite care is restricted to patients who meet the following criteria:

- The person is eligible for nursing services under the Home Care and Community Services Act, 1994.
 - The person must have an end-of-life home care designation to (service recipient code 95) and a prognosis of less than six (6) months.
 - The person needs to receive services in a residential setting, because:
 - The person requires a period of time in which to stabilize an exacerbation of life-limiting illnesses that puts her/him at risk of visiting an emergency room or hospital.
- OR
- The person requires 24/7 nursing support, but has primary caretakers who are experiencing significant stress and need to be temporarily relieved from their responsibilities for their own personal well-being.
 - The person must not have an anticipated discharge destination of a hospital or a long-term care home. If a patient's needs change over the course of their stay in the end-of-life respite program, discharges to other settings are not prohibited.
 - Persons with anticipated lengths of stay of greater than 14 days should not be admitted under normal circumstances. Contact the **Nurse Navigator at 289-921-0634** for consideration of extraordinary circumstances.