Ontario Health atHome

# Palliative Care – Community Services Assessment Request

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

## Important Instructions

- **Referrals without sufficient information will be returned to the referral source with further direction.**
- **Responsibility for medical care will remain with the primary care provider unless otherwise notified.**
- **Hospital referrers, please contact the Ontario Health atHome hospital care coordinator prior to discharge for an assessment to inform service planning.**

Please complete the referral form in its entirety and fax completed form to
Ontario Health atHome: **519-472-3257**
**** The referral will be triaged based on the information provided in this form ****

Attach relevant documents to support this referral (e.g. consult notes, current medication list, imaging results, etc.)

## Patient Information

| Surname | First Name | Date of Birth (DD-Month-YYYY) |
|---|---|---|
| | | |

| Home Address | City | Postal Code |
|---|---|---|
| | | |

| Health Card Number | Version Code | Phone Number |
|---|---|---|
| | | |

Does the patient prefer/need an alternate contact? If yes, indicate in the Alternate Contact Information section.
☐ No ☐ Yes

Assigned sex at birth
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Non-Binary ☐ Transgender Female ☐ Transgender Male ☐ Gender Variant/Non-conforming
☐ Prefer not to disclose ☐ Not Listed:

## Alternate Contact Information

| Surname | First Name |
|---|---|
| | |

| Relationship to Patient | Phone Number |
|---|---|
| | |

## Referral Urgency

Urgency of Referral
☐ 1-2 weeks (If care is required prior to this timeframe, please fax referral to 1-833-841-5369 and call 1-855-474-5754, 7 days a week, 0800-2000 hrs).
☐ 2+ weeks

## Primary Care Provider (PCP) Details

Does the patient have a PCP?
☐ Yes ☐ No

Is the PCP aware of the referral and that the responsibility for medical care will remain with the PCP unless otherwise notified?
☐ Yes ☐ No (If no, PCP must be made aware at earliest opportunity)

| Primary Care Provider Name | CPSO/CNO Registration (if applicable) |
|---|---|
| | |

| Daytime Phone Number | After-Hours Phone Number | Fax Number |
|---|---|---|
| | | |

| City | Postal Code |
|---|---|
| | |

| Surname | First Name | Health Card Number |
|---|---|---|
| | | |

## Pertinent Medical Information

| Primary Diagnosis | Date of Diagnosis (DD-Month-YYYY) |
|---|---|
| | |

Anticipated Prognosis

☐ days to weeks ☐ less than 3 months ☐ 3-6 months ☐ 6 months to one year

Pain and Symptoms

☐ Palliative Pain Location:

☐ Shortness of Breath: ☐ at rest ☐ on exertion ☐ home oxygen

☐ Nausea

☐ Other:

Health History (Please attach relevant medical documents)

Reason for Referral

☐ Ontario Health atHome Care Coordinator to Assess Eligibility for Home and Community Care Services

☐ Palliative MD/NP Consultation/Involvement

Details on Requested Support

Attach relevant documents (e.g. current medication list, imaging results, consult notes)

Palliative Performance Scale (PPS): See attached table to complete PPS.

☐ PPS 50% or more (up and out of chair/bed for more than half day, completes most activities of daily living [ADLs] on their own)

☐ PPS 40% (mostly in bed, assistance required for ADLs)

☐ PPS 30% or less (bed bound, complete care for ADLs, reduced/minimal oral intake)

Goals of care conversation (resuscitation status, care location, preferred end-of-life location, understanding of illness and treatment options) completed with patient/SDM

☐ No ☐ Yes

If YES, please provide details:

Resuscitation Status (If **not** discussed, please leave blank)

☐ Full Code (Cardiopulmonary Resuscitation [CPR] and all life-saving measures, transfer to acute care; default if patient is undecided)

☐ Do Not Resuscitate (DNR) (Please attach signed DNR-C, if available)

End-of-Life Preference

☐ Home ☐ Hospice ☐ Hospital ☐ Undecided ☐ Not discussed

| Surname | First Name | Health Card Number |
|---|---|---|
| | | |

## Consent and Referrer Details

☐ I have informed the patient/substitute decision maker (SDM) of this referral to receive palliative services and that he/she/they consented. Referral will be returned if consent has not been obtained from patient/SDM.

| Referrer Name and Designation | CPSO/CNO/College Registration | OHIP Billing Number |
|---|---|---|
| | | |

| Phone Number | Fax Number |
|---|---|
| | |

| Office Address |
|---|
| |

| City | Postal Code |
|---|---|
| | |

| Referrer Signature | Date Signed (DD-Month-YYYY) |
|---|---|
| | |

## Reminder

Please complete the referral form in its entirety and fax completed form to Ontario Health atHome at **519-472-3257**

**** The referral will be triaged based on the information in this form ****

Attach relevant documents to support this referral (e.g. current medication list, imaging results, consult notes)

The referral will be reviewed and services assessed by the Ontario Health atHome Care Coordinator for your patient. **Thank you for your submission.**

## Palliative Performance Scale (PPS version 2)

| PPS Level | Ambulation | Activity & Evidence of Disease | Self-Care | Intake | Conscious Level |
|---|---|---|---|---|---|
| 100% | Full | Normal activity & work<br>No evidence of disease | Full | Normal | Full |
| 90% | Full | Normal activity & work<br>Some evidence of disease | Full | Normal | Full |
| 80% | Full | Normal activity with effort<br>Some evidence of disease | Full | Normal or reduced | Full |
| 70% | Reduced | Unable normal job/work<br>Significant disease | Full | Normal or reduced | Full |
| 60% | Reduced | Unable hobby/house work<br>Significant disease | Occasional assistance necessary | Normal or reduced | Full<br>or confusion |
| 50% | Mainly Sit/Lie | Unable to do any work<br>Extensive disease | Considerable assistance required | Normal or reduced | Full<br>or confusion |
| 40% | Mainly in Bed | Unable to do most activity<br>Extensive disease | Mainly assistance | Normal or reduced | Full or drowsy<br>+/- confusion |
| 30% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total care | Normal or reduced | Full or drowsy<br>+/- confusion |
| 20% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total care | Minimal to sips | Full or drowsy<br>+/- confusion |
| 10% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total care | Mouth care only | Drowsy or coma<br>+/- confusion |
| 0% | Death | - | - | - | - |