Ontario Health atHome

# Palliative Patient Registry Referral Form

**Fax completed form to: 416 222-6517 / 905 952-2404**

**This form is not intended to communicate urgent health care needs. If you are referring a patient for urgent Ontario Health atHome services, please complete a Medical Referral Form.**

Ontario Health atHome Palliative Patient Registry supports patients who benefit from a palliative approach to care. Suitable patients are those who are in the end stage of a life limiting illness.

Once admitted to the Palliative Patient Registry, individuals will be regularly assessed, supported and linked to palliative resources by an Ontario Health atHome Care Coordinator.

## PATIENT INFORMATION

_____
*(Last Name, First Name)*

**Home Address:** _____ **DOB (dd-mmm-yyyy):** _____

**City:** _____ **Postal Code:** _____ **Home Phone:** _____

**Health Card Number and Version Code:** _____ **Gender:** ☐ Male ☐ Female

| | |
|---|---|
| Primary Contact: | Phone: |
| Primary Care Practitioner: | Phone: |
| Primary Diagnosis: | |
| Co-Morbidities: | |
| Has Advanced Care Plan been discussed? ☐ Yes ☐ No | |
| Is there a DNR in place? ☐ Yes ☐ No | |
| Estimated life expectancy 12 months or less? ☐ Yes – Proceed to complete rest of the form | ☐ No – Do not refer to registry at this time |

Palliative Performance Scale (PPS) Score:

☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

## Please check off general indicators of decline:

| | | | |
|---|---|---|---|
| ☐ | Advancing disease – unstable, deteriorating complex symptom burden | ☐ | Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity |
| ☐ | Decreasing response to treatments, decreasing reversibility | ☐ | Weight loss greater than 10% in past six months |
| ☐ | Choice of no further disease modifying treatment | ☐ | Repeated unplanned/crisis hospital admissions |
| ☐ | General physical decline | ☐ | Sentinel event, e.g. serious fall, bereavement, retirement on medical grounds |
| ☐ | Declining functional performance status, i.e. PPS less than or equal to 60%, reduced ambulation, increasing dependence in most activities of daily living | ☐ | Serum albumin Less than 25 g/L |

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# Palliative Patient Registry Referral Form

*(Patient Last Name, First Name)* **Health Card Number and Version Code:**

**Please check off specific clinical indicators of End Stage Disease:**

| CANCER | LUNG DISEASE (COPD) | HEART DISEASE (CHF) |
|---|---|---|
| ☐ Metastatic disease<br>☐ Spending more than 50% of time in bed/lying down | ☐ Disease assessed to be very severe (FEV1 less than 30% predicted)<br>☐ Recurrent hospital admissions (more than 3 in the last 12 months due to COPD)<br>☐ Dyspnea after 100 m on the level<br>☐ Signs and symptoms of right heart failure<br>☐ More than 6 weeks of systemic steroids for COPD in preceding 6 months | ☐ Stage 3 or 4<br>☐ Shortness of breath on minimal exertion<br>☐ Difficult physical or psychological symptoms despite optimal tolerated therapy |
| **RENAL DISEASE** | **NEUROLOGICAL DISEASE** | **DEMENTIA** |
| ☐ Stage 4 or 5<br>☐ No dialysis or discontinuing dialysis<br>☐ Difficult physical or psychological symptoms<br>☐ Symptomatic – nausea, vomiting, anorexia, pruritus, reduce functional status, intractable fluid overload | ☐ Symptoms which are too complex or too difficult to control<br>☐ Swallowing problems with recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure<br>☐ Speech problems<br>☐ Communication problems<br>☐ Cognitive decline<br>☐ Marked rapid decline in physical status<br>☐ Weight loss<br>☐ Low vital capacity (below 70% via spirometer) | ☐ Unable to walk without assistance<br>☐ Urinary and fecal incontinence<br>☐ No meaningful verbal communication<br>☐ Weight loss<br>☐ Urinary Tract Infection (UTI)<br>☐ Pressure sores<br>☐ Reduced oral intake<br>☐ Aspiration pneumonia |

**Please check off palliative resources you are suggesting:**

| | | |
|---|---|---|
| ☐ Caregiver Support<br>☐ Day Hospice<br>☐ End-of-Life Planning<br>☐ Hospice Volunteer<br>☐ Hospice Palliative Care (Advanced Practice Nurse) | ☐ Medication Management<br>☐ Palliative Physician<br>☐ Support Group<br>☐ Transportation to Appointments<br>☐ Visiting Hospice Program | Non-Urgent Services:<br>☐ Home Safety Assessment<br>☐ Palliative Nurse Practitioner<br>☐ Personal Support<br>☐ Visiting Nursing |

**Comments:**

**Completed By:** **Date:** *(dd-mmm-yyyy)*

**Professional Designation:**

**Organization:** **Phone:**

**If you have any questions, please call 905 895-1240 or 416 222-2241 ext. 5562** FIRST PAGE