

**TO ALL PALLIATIVE CARE PROVIDERS**

(For the purpose of this Form, an individual refers to a patient or client)

**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.**

Please complete this form as thoroughly as possible and PRINT clearly. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section.

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

Goals of Care/ Reason for Referral:

**Application Checklist (include if available):**

- Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)
- Communication to the individual's family physician of referral for palliative care services
- Copy of completed Do Not Resuscitate Confirmation Form
- Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI)       Recent chest x-ray
- Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.**
- Recent consultation notes       Recent laboratory results       Pathology reports

**Note:** Referral Source must be responsible to send referral to all services requested as indicated below. If urgency request is within 1-2 days, a phone contact must be made directly to the service request.

Type(s) of services requested	Urgency of response	Pages Required
<input type="checkbox"/> <b>Ontario Health atHome</b> (complete Medical Referral):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks	<b>Page 1-4</b>
<input type="checkbox"/> <b>Community Palliative Care Physician</b> (Specify Palliative Physician Team): Referral is for: <input type="checkbox"/> Consultative care <input type="checkbox"/> Primary care	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks	<b>Page 1-3</b>
<input type="checkbox"/> <b>Hospice Program:</b> <input type="checkbox"/> <b>Home Visiting</b> <input type="checkbox"/> <b>Day Program</b> <input type="checkbox"/> <b>Residential Hospice</b> (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future <input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	<b>Page 1-4</b>
<input type="checkbox"/> <b>Inpatient Palliative Care Unit</b> (List all units referred):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	<b>Page 1-4</b>
<input type="checkbox"/> <b>Other</b> (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future	<b>Page 1-4</b>

**Please send directly to your desired hospice palliative care provider(s). Do not send to the Ontario Health atHome Hospice Palliative Care Network.**

<sup>1</sup> The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Ontario Health atHome Central Hospice Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered. For more information, go to [www.tpcn.ca](http://www.tpcn.ca)

Individual's First & Last Name:

Home Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Entry Code: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Lives Alone  Young Children in the Home  Smoking in the Home  Pet in the Home (specify): \_\_\_\_\_

Home phone number: \_\_\_\_\_ Alternate number: \_\_\_\_\_

Date of birth: (DD/MM/YY) \_\_\_\_\_ Gender: \_\_\_\_\_ Faith/Religion: \_\_\_\_\_

Health card number: \_\_\_\_\_ Version code: \_\_\_\_\_

Primary language(s): \_\_\_\_\_ Translator: (name/phone #): \_\_\_\_\_

Current location:  Home  Residential hospice  Other (specify address): \_\_\_\_\_

Hospital Anticipated hospital discharge date: \_\_\_\_\_

Primary palliative diagnosis: \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Other relevant diagnosis/symptoms: \_\_\_\_\_

If cancer diagnosis: metastatic spread:  Yes  No Describe: \_\_\_\_\_

If cancer diagnosis: ongoing treatment:  Yes  No Describe: \_\_\_\_\_

Individual aware of: Diagnosis:  Yes  No Prognosis:  Yes  No Does not wish to know:  Yes  No

Family are aware of: Diagnosis:  Yes  No Prognosis:  Yes  No Does not wish to know:  Yes  No

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

Anticipated prognosis:  < 1 month  < 3 months  < 6 months  < 12 months  Uncertain

Determined by (name and phone number): \_\_\_\_\_

Functional status: Palliative Performance Scale (PPS): refer FAQs for more details

PPS:  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Resuscitation status: Life Support Decision:  CPR  No CPR  Unknown Decision

Discussed with: Individual  Yes  No Family  Yes  No

Family/Informal Caregivers: Provide Power Of Attorney for Personal Care if known: \_\_\_\_\_

Name	Relationship	Home Phone	Business/Cell Phone

Please list all Providers and Services currently involved: (if Known)  Additional list attached

Name	Phone	Fax
Family Physician:		
Nurse Practitioner:		
Care Coordinator*		
Community Nursing		
Hospice		
Other		

\*Ontario Health atHome

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Individual's First & Last Name:

Co-Morbidities:  Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

Infection Control:  MRSA/VRE (+)  C-DIFF (+)  Other (specify precaution): \_\_\_\_\_

Allergies:  Yes  No  Unknown  If Yes (please specify): \_\_\_\_\_

Pharmacy (name and number) If Known: \_\_\_\_\_

Current medications:  medication list attached

(Include complementary alternative medications and over-the-counter medications)

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Details of social situation, including any needs/concerns of the family:

Individual's First & Last Name:

**Special care needs: (please check all that apply)**

- Transfusion     Hydration:     SC or  IV     Infusion pump(s)     Total Parental Nutrition     Enteral feeds  
 Dialysis     Central line(s)     P.I.C.C. line(s)     PortaCath     Tracheostomy  
 Oxygen: rate: \_\_\_\_\_  Thoracentesis     Paracentesis     Drains/Catheter (specify): \_\_\_\_\_  
 Wound care (specify): \_\_\_\_\_  
 Therapeutic surface (specify): \_\_\_\_\_  
 Other needs: \_\_\_\_\_

**Symptom assessment:**

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

Pain \_\_\_\_\_ Tiredness \_\_\_\_\_ Nausea \_\_\_\_\_ Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Drowsiness \_\_\_\_\_  
Appetite \_\_\_\_\_ Well-Being \_\_\_\_\_ Shortness of Breath: \_\_\_\_\_ Other: \_\_\_\_\_

**Date ESAS completed:** \_\_\_\_\_

**Insurance Information:** \_\_\_\_\_

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

**For inpatient palliative care units:**     Private accommodation requested

**Any additional information:**

**Individual Completing Form:** \_\_\_\_\_ **Tel:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**(Referring) Physician:** \_\_\_\_\_ **Tel:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Date of Referral:** (DD/MM/YY) \_\_\_\_\_

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