

**Palliative Care Referral Form**



**TO ALL PALLIATIVE CARE PROVIDERS** (For the purpose of this Form, an individual refers to a patient and/or client)

Please complete this form<sup>1</sup> as thoroughly as possible. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section. Please ensure that the prescriber's signature is included where orders are given on page 6.

The CCAC "placement application form" no longer needs to accompany the Common Referral Form.

*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.*

**If this is being used to refer to a palliative care inpatient facility**

When the individual is ready for transfer to a palliative care facility, please contact the unit directly. Include the most recent clinical update and medication list and identify any special needs such as special mattresses or other surfaces required, nephrostomy tubes, chest tubes, intravenous access devices or infusion pumps, etc. in the transfer information package (refer to Page 3). Please note that **resuscitation is not offered** as part of the admission criteria for in-patient palliative care and residential hospice care. Definition of Cardiopulmonary Resuscitation (CPR) by Ministry of Health and Long-Term Care (MOHLTC) - is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardiorespiratory arrest. These measures include basic cardiac life support involving chest compressions, and/or artificial ventilation e.g. mouth-to-mouth resuscitation, bagging, and where available, defibrillation, intubation and other procedures considered to be Advanced Cardiac Life Support procedures by the Heart and Stroke Foundation of Ontario.

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

- Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **Reports must be current at time of referral and within the last 2 weeks as available. (If referring from acute care facility, this information must be included.)**
- Recent consultation notes
- Recent laboratory results
- Pathology reports
- Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI)       Most recent chest x-ray
- Care protocols attached e.g. wound care, central line care

**Referral Source:**

**Name & Discipline:** \_\_\_\_\_ **Tel.:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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

**Date of referral:** (DD/MM/YY) \_\_\_\_\_ **Date of birth:** (DD/MM/YY) \_\_\_\_\_ **Gender:** \_\_\_\_\_

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

**Primary language(s):** \_\_\_\_\_ **Faith/Religion:** \_\_\_\_\_

**Current location:**  Home  Residential hospice  Other (Specify address): \_\_\_\_\_  
 Hospital \_\_\_\_\_ Anticipated hospital discharge date: \_\_\_\_\_

**Home location:** (Address) \_\_\_\_\_ **Postal code:** \_\_\_\_\_

**Home phone number:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Alternate number:** ( ) \_\_\_\_\_ - \_\_\_\_\_

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

**Primary palliative diagnosis:** \_\_\_\_\_

**Metastatic spread, if malignant:** \_\_\_\_\_

**Reason for referral:**  Symptom management (specify): \_\_\_\_\_  
 Psychosocial Support  
 Respite/Support for caregiver  
 Assessment for Services  Activities Daily Living  Instrumental A.D.L. (eg. Shopping, banking)  
 Individual does not wish to die at home  Other (specify) \_\_\_\_\_

**Individual's goals of care:** \_\_\_\_\_

**Anticipated prognosis:**  < 1 month  < 3 months  < 6 months  < 12 months  Uncertain  
 Determined by: \_\_\_\_\_

**For CCAC purposes, is death anticipated within the next 6 – 12 months?**  Yes  No

**Individual aware of:**  Diagnosis  Prognosis  Does not wish to know

**Family are aware of:**  Diagnosis  Prognosis  Does not wish to know

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

**Resuscitation status:**  Do Not Resuscitate  Resuscitate (**Note: If this box is checked, individual is NOT eligible for PCU and Residential Hospice**)  
 Do Not Resuscitate Confirmation Form Completed

**Substitute Decision Maker:**

	Name	Home Phone	Business/Cell Phone
Power of Attorney (POA) for Personal Care <input type="checkbox"/> Documentation attached			
If no POA, substitute decision maker according to the legislated hierarchy			

**Advance Care Directive in place should individual be incapable as per Health Care Consent Act 1996<sup>2</sup>:**  Yes  No

**Documentation attached:**  Yes  No

Type(s) of services requested	Urgency of response	List all placement referrals made: 1) 2) 3)
<input type="checkbox"/> Inpatient Palliative Care Unit	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Residential Hospice	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> Future	
<input type="checkbox"/> Home hospice Program	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Day Hospice Program	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Community visiting (e.g. Interlink nurse, physician team, etc.) – LIST SERVICE REQUESTED:	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> CCAC	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Palliative Pain/Symptom Management Consultant (PPSMC)	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Palliative Care Community Team	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	

<sup>2</sup> The Health Care Consent Act 1996, c. 2, Sched. A, s. 4 (1).states "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision". Page 2 of 6

Individual's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Please list all Providers currently involved:

Name	Phone	Fax
<input type="checkbox"/> Additional list attached		

**Symptom assessment**

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

Date completed: \_\_\_\_\_

Pain \_\_\_\_\_ Tiredness \_\_\_\_\_ Nausea \_\_\_\_\_ Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Drowsiness \_\_\_\_\_

Appetite \_\_\_\_\_ Well-being \_\_\_\_\_ Shortness of breath \_\_\_\_\_ Other: \_\_\_\_\_

**Bowel function:** Constipation:  Yes  No Last normal BM: \_\_\_\_\_ Diarrhea:  Yes  No Frequency: \_\_\_\_\_

**Bladder function:**  Continent  Incontinent  Catheter

**Symptom(s) most distressing to the individual:**

\_\_\_\_\_

\_\_\_\_\_

**Current Care needs:** (please check all that apply)

- Transfusion:  Hydration:  SC or  IV  Enteral feeds  Central line(s)  P.I.C.C. line(s)  PortaCath
- Dialysis  Oxygen  Chest tube(s)  Thoracentesis  Paracentesis
- Feeding tube  Infusion pump(s)  Pressure ulcer(s)  Ostomy care  Tracheostomy

Wound care (specify): \_\_\_\_\_

Therapeutic surface (specify): \_\_\_\_\_

Other needs: \_\_\_\_\_

**Special needs:**  MRSA/VRE (+)  C-DIFF (+)  Other (specify precaution): \_\_\_\_\_

**Symptom Management Kit in the home?**  Yes  No  Not Known

**Prior treatment for diagnosis?**  Radiotherapy Date: \_\_\_\_\_  Chemotherapy Date: \_\_\_\_\_

Surgery Date: \_\_\_\_\_  Other: \_\_\_\_\_ Date: \_\_\_\_\_

**Ongoing treatment for diagnosis?**  Radiotherapy  Surgery  Chemotherapy: Last treatment date: \_\_\_\_\_

Other: \_\_\_\_\_

**Does the individual have a Family Physician/General Practitioner?**  Yes  No

If Yes, Contact Information: \_\_\_\_\_

Will this Provider make home visits?  Yes  No

**Health History:** (please attach a printout if available)  Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

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

**Present medications:**  Check here if additional medication documentation is attached

(Include complementary alternative medications and over the counter medications)

Drug	Dose	Route	Interval

**Allergies:**  None known  Present (please specify) \_\_\_\_\_

Approximate Height: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_

**Functional status:** Palliative Performance Scale (PPS) at time of referral (refer to Victoria Hospice Society, PPSv2/ Cancer Care Ontario for definition).  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

**Mobility:**  Ambulatory  Ambulatory with aid  Ambulatory with people  Bed-ridden

**Cognition:**  Alert  Altered Cognition  Responsive to Stimuli  Unresponsive

**Bathing:**  Independent  With assistance  Total assist

**Feeding:**  Independent  With assistance  Total assist  NPO

Difficulty swallowing (describe): \_\_\_\_\_

Diet Type: \_\_\_\_\_  Diet Texture: \_\_\_\_\_  Other: \_\_\_\_\_

**Other:**  Vision impaired  Hearing impaired  Speech impaired

Behaviour (describe): \_\_\_\_\_

**Family/Informal Caregivers:**

Name	Relationship	Name	Relationship

**Psychosocial and Spiritual status and concerns:**

Issue	Yes	No	Unknown	Description
Spiritual Distress				
Financial Concerns				
Family Issues				
Past Substance Use				
Current Substance Use				
Other				

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

**Insurance information (if known):** \_\_\_\_\_

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

**For inpatient palliative care units:**

Semi-private accommodation requested       Private accommodation requested       Co-payment fees reviewed (where appropriate)

**Details of social situation:**

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**Any additional information appropriate:**

**Form completed by** (print/signature): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Telephone and pager number** (if different from referral source): \_\_\_\_\_



Individual's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**PLEASE COMPLETE THIS SECTION OF THE FORM FOR ANY REFERRAL TO CCAC AND INCLUDE PAGES 1-5 WITH THIS REFERRAL**

*(Treatments will be taught/reduced unless otherwise indicated)*

<b>Service requested:</b>		Prescriber's Orders:
Nursing	<input type="checkbox"/>	
Dietician	<input type="checkbox"/>	
Occupational therapy	<input type="checkbox"/>	
Personal support	<input type="checkbox"/>	
Physiotherapy	<input type="checkbox"/>	
Social work	<input type="checkbox"/>	
Speech therapy	<input type="checkbox"/>	
Laboratory tests (Where Applicable)	<input type="checkbox"/>	Type(s) and frequency: _____ _____
		Report results to: _____
		Start date: _____ / _____ / _____
Other (specify): _____	<input type="checkbox"/>	

Signature of Prescriber: \_\_\_\_\_ Designation: \_\_\_\_\_

**Medical Supervision while on CCAC services**

<b>Referring Physician (Attending):</b> _____	<b>Most Responsible Physician:</b> _____ <input type="checkbox"/> Check if same as Attending Physician
Staff physician's name (if applicable):	Name:
Name:	Address:
Address:	Office phone number:
Phone number:	After hours phone number:
Specialty:	Fax number:
OHIP billing code:	Specialty:
Signature:	OHIP billing code:
Signature date:	Has this physician been contacted and agrees: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Contacted by:
	Date of contact:
	Date of next medical appointment: