Ian Anderson House Residential Hospice Referral

Attention: Intake Nurse Ian Anderson House 430 Winston Churchill Blvd Oakville, ON L6J 7X2 Ph: (905) 337-8004 Fax: (905) 337-8006	Name: _____ ☐M ☐F ☐Other Address: _____ City: _____Postal Code: _____ DOB: (DY/MO/YR) _____ Telephone: _____ HCN: _____ Primary Language: _____
Referred by: _____ Diagnosis: _____ Patient Aware of Referral: Yes ☐ No ☐ Current Location: Home ☐ Hospital ☐ Other ☐ IAH as Primary Choice ☐ Back-up Plan ☐ Referral shared with another hospice: Yes ☐ No ☐ If yes, where? _____	Primary Contact: _____ Phone: _____ SDM: _____ Phone: _____ PPS: 10 20 30 40 50 60 or > (Circle one) **DNR:** Yes ☐ No ☐ Life Expectancy: days to weeks ☐ 1-2 months ☐ 3-6 months ☐ Uncertain ☐

BRIEF HISTORY – including any physical, psychological and/or social-family needs:

Special requirements: Drains☐ Wounds☐ Oxygen (rate)☐ CADD☐
Other:

REFERRAL MUST INCLUDE:
Recent Medical Notes and Diagnostic Records attached ☐
COVID Testing date: Pos ☐ Neg ☐ Performing Lab:

PLEASE LIST PROVIDERS CURRENTLY INVOLVED:

Name	Contact Phone Number
Current MRP:	
Family Physician/Nurse Practitioner:	
Palliative Physician:	
HCCSS Care Coordinator:	

Signature: _____ Date: _____