SouthlakeHealth

Hospice Palliative Care Team
596 Davis Drive
Newmarket, ON L3Y 2P9
Tel: 905-895-4521, ext. 6388
Fax: 905-830-5978

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: (Print first, last) _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Hospice Palliative Care Team Referral Form

Please fax to 905-830-5978

Date of Referral: *(dd/mm/yyyy)* ____ / ____ / _____ **Urgency:** ☐ 1-2 days - *call HPCT & indicate reason for urgency* ☐ within 1 week ☐ 1-2 weeks		
Patient Name: *(print first, last)*		
Address: Street Number + Name Apartment		
City Province Postal Code		
Health Card Number:	Version Code:	Date of Birth *(dd/mm/yyyy)*: _____/_____/_____
Home Phone: ( )	Alternate Phone: ( )	Gender at Birth: ☐ Female ☐ Male
Primary Contact Person Name/Relationship:		Phone: ( )
Secondary Contact Person Name/Relationship:		Phone: ( )
Primary Care Physician Name:		Phone: ( )
Is a Home Visiting Physician assigned? ☐ Yes ☐ No	Physician:	Phone: ( )

REASON FOR REFERRAL:

Patient aware of referral: ☐ Yes ☐ No Family aware of referral: ☐ Yes ☐ No

☐ Pain and Symptom Management Consultation ☐ Referral to Palliative Physician

☐ Other - please specify:

Primary Palliative Diagnosis:

Other Relevant Diagnosis/Symptoms:

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If Cancer Diagnosis - Metastatic Spread:	☐ Yes ☐ No *Sites:*
If Cancer Diagnosis Ongoing Treatment:	☐ Yes ☐ No *Describe:*
Individual aware of diagnosis:	☐ Yes ☐ No ☐ Does not wish to know
Family are aware of diagnosis:	☐ Yes ☐ No *If family is not aware, individual has given consent to inform family of diagnosis:* ☐ Yes ☐ No
Individual aware of prognosis:	☐ Yes ☐ No ☐ Does not wish to know
Anticipated Prognosis:	☐ Less than 1 month ☐ Less than 3 months ☐ Less than 6 months ☐ Less than 12 months ☐ Uncertain
Resuscitation Status:	Do Not Resuscitate ☐ Yes ☐ No
Discussed With:	Individual: ☐ Yes ☐ No Family: ☐ Yes ☐ No
Hospice Referral:	Name: Phone Number: ( )
Psychosocial:	
Current Medications:	

PRESENTING SYMPTOMS (ESAS Scores):

Rate symptoms: **0**=no symptom **10**=worst symptom

Pain: ____ /10	Drowsiness: ____ /10	Depression: ____ /10	Other: ____ /10 *Please specify:*
Anxiety: ____ /10	Nausea: ____ /10	Wellbeing: ____ /10	
Tiredness: ____ /10	Appetite: ____ /10	SOB: ____ /10	

Palliative Performance Scale (PPS)

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

Patient receiving Ontario Health at Home Services?	☐ Yes ☐ No
Care Coordinator Name:	
Nursing Agency:	
Nurse Name:	

REFERRAL SOURCE

Form completed by:		Signature:
Date of Referral: *(dd/mm/yyyy)* ____ / ____ / ____	Phone: ( )	Fax: ( )
Referring Physician		Billing #:
Phone: ( )	Fax: ( )	Physician Signature: