MISSISSAUGA HALTON PALLIATIVE CARE NETWORK

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[1] 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 ❑ 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* [2]: ❑ Yes ❑ No

Documentation attached: ❑ Yes ❑ No

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

[2] 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".

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

Please list all Providers currently involved:

Name	***Phone***	***Fax***
❑ 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 Physican/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:

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)

Service requested:		Prescriber's Orders:
Nursing	❑	
Dietician	❑	
Occupational therapy	❑	
Personal support	❑	
Physiotherapy	❑	
Social work	❑	
Speech therapy	❑	
Laboratory tests (Where Applicable)	❑	Type(s) and frequency: _____ _____ Report results to: _____ Start date: _____ / _____ / _____
Other (specify): _____	❑	

Signature of Prescriber: _____ **Designation**: _____

Medical Supervision while on CCAC services

Referring Physician (Attending): _____	***Most Responsible Physician:*** _____ ❑ ***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: ❑ Yes ❑ No
	Contacted by:
	Date of contact:
	Date of next medical appointment: