



Ian Anderson House Residential Hospice Referral

<p style="text-align: center;">Attention: Intake Coordinator</p> <p style="text-align: center;"> Ian Anderson House 430 Winston Churchill Blvd Oakville, ON L6J 7P5 Ph: (905) 337-8004 Fax: (905) 337-8006 </p>	<p>Name: _____ M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Address: _____</p> <p>City: _____ PostalCode: _____</p> <p>DOB: (DY/MO/YR) _____</p> <p>Telephone: _____</p> <p>HCN: _____</p> <p>Primary Language: _____</p>										
<p>Referred by: _____</p> <p>Diagnosis: _____</p> <p>Patient Aware of Referral: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Current Location: Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/></p> <p>IAH as Primary Choice <input type="checkbox"/> Back-up Plan <input type="checkbox"/></p> <p>Referral shared with other hospice: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="margin-left: 20px;">If yes, where ? _____</p>	<p>Primary Contact: _____</p> <p>Phone: _____</p> <p>SDM: _____</p> <p>Phone: _____</p> <p>PPS: 10 20 30 40 50 60 or > (Circle one)</p> <p>DNR: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="margin-left: 40px;">Life Expectancy: days to weeks <input type="checkbox"/> 1-2 months <input type="checkbox"/></p> <p style="margin-left: 80px;">3-6 months <input type="checkbox"/> Uncertain <input type="checkbox"/></p>										
<p><u>BRIEF HISTORY</u> – including any physical, psychological and/or social-family needs:</p> 											
<p>Special requirements: Drains <input type="checkbox"/> Wounds <input type="checkbox"/> Oxygen (rate) <input type="checkbox"/> CADD <input type="checkbox"/></p> <p>Other: _____</p>											
<p><u>REFERRAL MUST INCLUDE:</u></p> <p>Recent Medical Notes and Diagnostic Records attached <input type="checkbox"/></p> <p>COVID Testing date: _____ Pos <input type="checkbox"/> Neg <input type="checkbox"/> Performing Lab: _____</p>											
<p><u>PLEASE LIST PROVIDERS CURRENTLY INVOLVED:</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Name</th> <th>Contact Phone Number</th> </tr> </thead> <tbody> <tr> <td>Current MRP:</td> <td></td> </tr> <tr> <td>Family Physician/Nurse Practitioner:</td> <td></td> </tr> <tr> <td>Palliative Physician:</td> <td></td> </tr> <tr> <td>LHIN Care Coordinator:</td> <td></td> </tr> </tbody> </table>		Name	Contact Phone Number	Current MRP:		Family Physician/Nurse Practitioner:		Palliative Physician:		LHIN Care Coordinator:	
Name	Contact Phone Number										
Current MRP:											
Family Physician/Nurse Practitioner:											
Palliative Physician:											
LHIN Care Coordinator:											

Signature: _____

Date: _____