

Addressograph

TO ALL PALLIATIVE CARE PROVIDERS

(For the purpose of this Form, an individual refers to a patient or client)

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 which you are submitting this. Please also include your Organization's Release of Information Form, if applicable.

Please complete this form as thoroughly as possible and PRINT clearly. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section.

Goals of Care/Reason for Referral:

Application Checklist (include if available):

- Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)
 - Communication to the individual's family physician of referral for palliative care services
 - Copy of completed Do Not Resuscitate Confirmation Form
 - Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) Recent chest x-ray
 - Infection control management (e.g. MRSA/VRE/C-DIFF, etc.)
- As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.**
- Recent consultation notes Recent laboratory results Pathology reports

Note: Referral Source must be responsible to send referral to all services requested as indicated below. If urgency request is within 1-2 days, a phone contact must be made directly to the service request.

Types(s) of services requested	Urgency of response	Pages Required
<input type="checkbox"/> Community Care Access Centre (complete CCAC Medical Referral Form):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1-2 weeks	Page 1-4
<input type="checkbox"/> Campbellford Memorial Hospital (direct admit for symptom management): 705-653-1140 ex 2143. Fax:705-653-3020	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> Future	Page 1-3
<input type="checkbox"/> Hospice Program (home visiting): 866-514-5774. Fax:905-372-3898	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> Future	Page 1-4
<input type="checkbox"/> Residential Hospice: 705-924-9222 Fax: 705-924-9916	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> Future	Page 1-3
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> Future	Page 1-3

Please send directly to your desired hospice palliative care provider(s). Do not send to the Trent Hills Palliative Care Network.

The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Hospice Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered. For more information, go to www.tpcn.ca

Palliative Care Common Referral Form

Trent Hills Palliative Care Network

Individual's First & Last Name:

Home Address: _____ Apt: _____ Entry Code: _____ Postal Code: _____

Home phone number: _____ Alternate number: _____

Date of birth: (DD/MM/YY): _____ Gender: _____ Faith/Religion: _____

Health card number: _____ Version code: _____

Primary language(s): _____ Translator (name/phone #): _____

Current location: Home Residential Hospice Other (specify address): _____

Hospital _____ Anticipated hospital discharge date: _____

Lives Alone Young Children in the Home Smoking in the Home

Pet in the Home (specify): _____

Family/Informal Caregivers: Provide Power Of Attorney for Personal Care if known: _____

Name	Relationship	Home Phone	Business/Cell Phone

Primary Palliative Diagnosis: _____ Date of Diagnosis: _____

Other relevant diagnosis/symptoms: _____

If diagnosis: metastatic spread: Yes No Describe: _____

If diagnosis: ongoing treatment: Yes No Describe: _____

Individual/Family aware of: Diagnosis: Yes No Prognosis: Yes No Does not wish to know: Yes No

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

Anticipated prognosis: < 1 month < 3 months < 6 months < 12 months Uncertain
Determined by _____

Functional status: Palliative Performance Scale (PPS): refer FAQs for more details

PPS: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Stable Changing

Resuscitation status: Do Not Resuscitate Yes No Unknown

Frailty Score: 5 6 7 8 9

Discussed with: Individual Yes No Family Yes No

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Trent Hills Palliative Care Network

Individual's First & Last Name:

Please list all Providers and Services currently involved: (if known) Additional list attached

Name	Phone	Fax
Family Physician:		
CCAC		
Community Nursing		
Hospice		
Other		

Co-Morbidities: Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

Infection Control: MRSA/VRE (+) C-DIFF (+) Other (specify precaution): _____

Allergies: Yes, specify: _____ No Unknown

Pharmacy (name and number) If Known: _____

Current medications: medication list attached
(Include complementary alternative medications and over-the-counter medications)

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Special care needs: (please check all that apply)

- Transfusion Hydration: SC or IV Infusion pump(s) Total Parental Nutrition Enteral Feeds
- Dialysis Central line(s) P.I.C.C. line(s) PortaCath Tracheostomy
- Oxygen: rate: _____ Thoracentesis Paracentesis Drains/Catheter (specify): _____
- Wound care (specify): _____
- Therapeutic surface (specify): _____
- Other needs: _____

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Individual's First & Last Name:

Any additional information: Details of social situation, including any needs/concerns of the family:

Individual Completing Form: _____ Tel: _____ Fax: _____

(Referring) Physician: _____ Tel: _____ Fax: _____

Date of Referral: (DD/MM/YY): _____

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