# FOUR COUNTIES HEALTH SERVICES

## PALLIATIVE CARE REFERRAL FORM

**REASON FOR REFERRAL:** _____

Non-urgent ☐ Urgent (within 24 hours) ☐ Reason for urgency: _____

Is this a Pre-planned referral for future admission? Yes ☐ No ☐ (**check Preference below**)
☐ No Preference ☐ Prefers Residential Hospice ☐ Prefers LTC/Retirement home ☐ Prefers Home
☐ If preferred location choice not available, would consider an alternate location
Offered Hospice or CCAC Palliative Home Care? Yes ☐ No ☐ If yes where: _____

Has Palliative Care Consult occurred: Yes ☐ No ☐ If yes where: _____

| **PATIENT'S PERSONAL INFORMATION** | **DATE OF REFERRAL:** | **DD:** | **M:** | **YR:** |
|---|---|---|---|---|
| Last name | First Name | | PIN# | |
| Address: | Apt# | City/Province | Postal code | |
| Home Tel: | Date of Birth YYYY/MM/DD | Male ☐ Female ☐ | Preferred language | |
| Primary Care Provider: | Phone: | Fax: | Is PCP aware of referral: Yes ☐ No ☐ | |

| **REFERRAL SOURCE:** | | | |
|---|---|---|---|
| Facility/Community Agency: | | Present Location: | |
| Primary Clinical Contact: | Phone: | Pager: | Is the primary contact aware of referral: Yes ☐ No ☐ |

Current Palliative Management by: Primary Care Provider ☐ Palliative Specialist ☐

**Resuscitation/End of Life Care Plan: ☐ DNR in place ☐ DNR not in place**

| **CURRENT CARE NEEDS:** | | | | | | |
|---|---|---|---|---|---|---|
| Transfusion ☐ | Hydration ☐ | SC ☐ IV ☐ | Infusion Pumps ☐ | Central Line (s) ☐ | PICC line ☐ | Enteral Feeds ☐ |
| Dialysis ☐ | Trancheostomy ☐ | Oxygen rate ☐ | Thoracentesis ☐ | Paracentesis ☐ | Ostomy ☐ | Foley ☐ |
| Spinal analgesia Yes ☐ No ☐ | | Chronic Mechanical ventilation ☐ Invasive ☐ CPap ☐ BiPap | | Chest tube/pleurex: Yes ☐ No ☐ | | MRSA + ☐ - ☐ cDiff + ☐ - ☐ |

**Ongoing treatment**: Radiation ☐ Chemotherapy ☐ Antibiotics: Oral ☐ IV ☐
**Purpose of treatment**: Life extending ☐ Comfort Measures ☐

| **CLINICAL INFORMATION:** | |
|---|---|
| Primary diagnosis | **Is patient/family aware of diagnosis/prognosis:** Yes: ☐ No: ☐ |
| Palliative Performance Scale (PPS) % | Date PPS completed: |
| Anticipated prognosis: ≤2 week ☐ <1 month ☐ <3 months ☐ < 6 months ☐ | As assessed by: |
| **Current Edmonton Symptom Assessment System (ESAS) score at time of referral:**<br>**Please rate symptoms: 0 = no symptom, 10 = worst symptom**<br>**Date of ESAS completed:** | Other: |

| Pain | Tiredness | Nausea | Depression | Drowiness | Anxiety | Appetite | Well-being | SOB |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**FOUR COUNTIES HEALTH SERVICES**

# PALLIATIVE CARE REFERRAL FORM

| Referral for Palliative Care – Patient Name/PIN: | | | | |
|---|---|---|---|---|
| What services might Patient, SDM and or family require: | **PT** | **Dietary** | **Social Work** | **Other:** |

**ADDITIONAL CARE NEEDS (which may impact service delivery) :**

Wound Care & Percutaneous Drains:

Bowel management concerns:

Other needs: (e.g. bariatric, dementia, communication aid)
If Bariatric, Weight:

Assistance needed for transfers & mobility including gait aids: (e.g. assist x1, x2 or lift):

Therapeutic surface ( air mattress etc):

Additional information: (Smoker, Substance abuse; please comment on any relevant social information)

**HEALTH INSURANCE INFORMATION**

Health Insurance Number Version Code:

**HEALTH CARE DECISION MAKING**

Power of Attorney for Personal Care (if not in place identify SDM for Personal Care)

| Name | Home Phone# | Bus/Cell # |
|---|---|---|
| Name | Home Phone# | Bus/Cell# |

Has the patient and/or SDM agreed to this referral? Yes ☐ No ☐
Has SDM/family contacted a funeral home? Yes ☐ No ☐

PATIENT GOALS:

| Form completed by: | Role/title: | Signature: |
|---|---|---|

**SUPPORTING DOCUMENTATION** – Please fax Admission History, Consult Reports, Recent Progress Notes, MAR, DNR form, POA doc, Wound Care Plan, Behaviour Management Plan, Applications for hospice or LTC if in progress, Living will, and any special request/wishes patient and/or SDM may request such a religious or cultural practices if applicable to:

**FOUR COUNTIES HEALTH SERVICES**
**ACTIVE CARE NUSING UNIT**
**Fax: 519-693-6512**