# PALLIATIVE CARE BED REFERRAL FORM

**REASON FOR REFERRAL:** _____

Non-urgent ☐ Urgent ☐ (within 24 hours)

Reason for urgency: _____

Date last seen by MRP/NP: _____

Is this a Pre-planned referral for future admission ☐ (***Check Preference below***)

☐ *No Preference* ☐ *Prefers Residential Hospice* ☐ *Prefers Parkwood Palliative Care Unit*

☐ *If preferred location choice not available, would consider the alternate location*

Has Palliative Care Consult occurred: Yes☐ No☐

| **PATIENT'S PERSONAL INFORMATION** *If LHSC Patient only require NAME & PIN #* | **DATE OF REFERRAL:** | **DD:** | **M:** | **YR:** |
|---|---|---|---|---|

| Last Name | First Name | **PIN #** |
|---|---|---|

| Address | Apt # | City/Province | Postal |
|---|---|---|---|

| Home Telephone: | 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☐ Provider Name**:**

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

**CURRENT CARE NEEDS:**

| Transfusion ☐ | Hydration ☐ | SC ☐ IV ☐ | Infusion Pumps ☐ | Central Line(s) ☐ | PICC Line ☐ | Enteral Feeds ☐ |
|---|---|---|---|---|---|---|
| Dialysis ☐ | Tracheostomy ☐ | 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: < 1 week☐ < 1 month☐ <3 months☐ < 6 months☐** As assessed by:

**Current Edmonton Symptom Assessment System (ESAS) score at time of referral:** ***Please rate symptoms: 0 = no symptom, 10 = worst symptom*** **Date of ESAS completed:** **Other:**

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

Any medications not covered by ODB or third party coverage:

**Referral for Palliative Care – Patient Name/PIN:** _____

| |
|---|
| Wound Care & Percutaneous Drains: |
| Bowel management concerns: |
| Other needs: (e.g bariatric) Weight: |
| Assistance needed for transfers & mobility including gait aids:(e.g. assist x1 /x2 or lift): |
| |
| Therapeutic surface: |
| Additional information: (Smoker, Substance abuse; please comment on any relevant social information) |
| |
| |
| |
| |

| **HEALTH INSURANCE INFORMATION** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Health Insurance Number | | | | | | | | | | | Version Code: |

| **HEALTH CARE DECISION MAKING** *Please complete if patient* | | |
|---|---|---|
| **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** ☐ | | |

| **PATIENT'S GOALS:** | | |
|---|---|---|
| | | |
| Form completed by: | Role/title: | Signature: |

| **SUPPORTING DOCUMENTATION - Please fax Admission History, Consult Reports, Recent Progress Notes, Current Medication List and if applicable Wound Care Plan & Behaviour Management Plan.<br>**For Hospice/Parkwood - Most Recent MRP Notes & Care Coordinator Updates**** | |
|---|---|
| If referring to Parkwood | Fax to Parkwood Access - 519-685-4804 |
| If referring to Hospice | Ensure hardcopy form is provided to CCAC |
| No preference on bed location: | Application needs to be sent to both CCAC & Parkwood Access |

Unless you tell us otherwise, your personal information and personal health information will be shared with health care providers at CCAC, London Health Sciences Centre, St. Joseph's Health Care London, and St. Joseph's Hospice, who may become part of your health care team for the purpose of your continuing care. (**Form revised: September 16, 2016**)