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 whom 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.

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

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 above; If urgency request is within 1-2 days, a phone contact must be made to the service request

Type(s) of services requested	Urgency of response	Pages Required
☐ **Community Care Access Centre** (complete CCAC Medical Referral Form):	☐ 1-2 days ☐ 1 - 2 weeks	**Page 1-4**
☐ **Community Palliative Care Physician** (Specify Palliative Physician Team): Referral is for: ☐ Consultative care ☐ Primary care	☐ 1-2 days ☐ 1 - 2 weeks	**Page 1-3**
☐ **Hospice Program**: ☐ **Home Visiting** ☐ **Day Program** ☐ **Residential Hospice** (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future ☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**
☐ **Inpatient Palliative Care Unit** (List all units referred):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**
☐ **Other** (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future	**Page 1-4**

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

[1] The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered.

Palliative Care Common Referral Form | Toronto Central Palliative Care Network

Individual's First & Last Name:

Home Address: ________ **Apt:** ____ **Entry Code:** ____ **Postal Code:** ____

☐ Lives Alone ☐ Young Children in the Home ☐ Smoking in the Home ☐ Pet in the Home *(specify):* ____

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: ________

Primary palliative diagnosis: ________ **Date of Diagnosis** ________

Other relevant diagnosis/symptoms: ________

If cancer diagnosis: metastatic spread: ☐ Yes ☐ No Describe: ________

If cancer diagnosis: ongoing treatment: ☐ Yes ☐ No Describe: ________

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

Family are 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 *(name and phone number)*: ________

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

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

Resuscitation status: Do Not Resuscitate ☐ Yes ☐ No Unknown ☐

Discussed with: Individual ☐ Yes ☐ No Family ☐ Yes ☐No

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

Name	Relationship	Home Phone	Business/Cell Phone

Please list all Providers and Services currently involved*:* (if Known) ☐ Additional list attached

Name	*Phone*	*Fax*
Family Physician:		
CCAC		
Community Nursing		
Hospice		
Other		

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

Individual's First & Last Name:

Co-Morbidities: ☐ **Check here if documentation is attached**

Year	Diagnosis	Year	Diagnosis

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(specify precaution)*: ______________________

Allergies: ☐ Yes ☐ No ☐ Unknown ☐ If Yes (please specify): ______________________

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

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

Individual's First & Last Name:

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: ____________

Symptom assessment:

ESAS Score at the time of referral: *(Adapted from Edmonton Symptom Assessment System—ESAS, Capital Health, Edmonton)*
(rate symptoms: 0 = no symptom, 10 = worst symptom possible – See FAQs for details):

Pain ______ Tiredness ______ Nausea ______ Depression ______ Drowsiness ______ Appetite ______

Well-being ______ Shortness of breath ______ Other: ____________

Date ESAS completed: ____________

Insurance Information: ____________

Has expressed willingness to pay for private services: ☐ Yes ☐ No ☐ Not Known

For inpatient palliative care units: ☐ Private accommodation requested

Any additional information:

Individual Completing Form: ____________ **Tel:** ____________ **Fax:** ____________

(Referring) Physician: ____________ **Tel:** ____________ **Fax:** ____________

Date of Referral: (*DD/MM/YY*) ____________

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