Palliative Care Hospice & In-Patient Referral

Date of Application:		Date of Admission:		BRN:	

Personal Information

Last Name	First Name			
Date of Birth	Age			☐ Male ☐ Female
Address	Unit #	City	Prov.	Postal Code
Home Telephone	Present Location (home, hospital, LTC, ED)			
Family Physician/Primary Care Practitioner	Phone	Fax		
Most Responsible Physician	Phone	Fax		
Nurse Practitioner	Phone	Fax		

Health Insurance Information

Is patient covered under Ontario Health Insurance Plan? ☐ No ☐ Yes	Last name on health card:	Health Insurance Number	Version Code
Accommodation preferred: ☐ Ward ☐ Semi-private ☐ Private		Insurance attached: ☐ No ☐ Yes	

Primary Contact Information

Name	Relationship	Substitute Decision Maker (SDM) ☐ Yes ☐ No	
Power of Attorney for Personal Care? ☐ Yes ☐ No (Please attach document)	Power of Attorney for Property Decisions? ☐ Yes ☐ No (Please attach document)		
Address	City	Prov.	Postal Code
Telephone (home) Telephone (cell)	Telephone (work)		Ext.

Alternate Contact Information

Name	Relationship	Substitute Decision Maker (SDM) ☐ Yes ☐ No	
Power of Attorney for Personal Care? ☐ Yes ☐ No (Please attach document)	Power of Attorney for Property Decisions? ☐ Yes ☐ No (Please attach document)		
Address	City	Prov.	Postal Code
Telephone (home) Telephone (cell)	Telephone (work)		Ext.

Patient/SDM (if mentally incapable) requesting resuscitation or other life sustaining interventions? ☐ Yes ☐ No
(Please note, resuscitation is not a treatment option for EOL care)

Current Isolation Issues: ☐ Yes ☐ No	**Positive for**: ☐ MRSA ☐ VRE ☐ C Diff. ☐ Other (C Diff is an exclusion criteria for all hospice sites)

Outstanding Medical Investigations:

FAX COMPLETED FORM TO CCAC 519-742-0635

(Patient Name/Label)

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Admission Location Requested:	Please select the patient's site choice. For multiple choices, please rank site choice from 1 to 6. (1= First choice, 2= Second choice, 3= Third choice, 4 = Fourth choice, 5 = Fifth choice, 6 = Sixth choice)
	Lisaard House - Cambridge ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th Innisfree House - Kitchener ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th GRH Freeport - Kitchener ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th
	Hospice Wellington - Guelph ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th SJHCG - Guelph ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th GMCH- Fergus ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th

Crisis: Is the patient in Crisis ☐ Yes ☐ No

Referral Source :

☐ Hospital In-patient unit ☐ Hospital – ED ☐ Community

Facility / Community Agency:			Location/Unit:
Bed Offer First Contact Person:			
Phone:	ext:	Pager:	Fax:
Bed Offer Second Contact Person (if applicable):			
Phone:	ext:	Pager:	Fax:
Primary Palliative Diagnosis:			Date of Diagnosis:
Metastatic Spread (if malignant)			
Relevant Co-morbidities			

Reason for Referral

☐ **Pain & Symptom Management** ESAS: (attach if available)
What are the symptoms that require management?

☐ **End of Life Care (EOL)**
- ☐ EOL care needs exceed capacity of care at home
- ☐ Caregiver/s and/or informal supports inability to cope at home
- ☐ Individual does not wish to die at home
- ☐ Other (specify): _____

☐ **Back Up Plan** (Hospice sites only)

Prognosis

Most recent PPS Score: _____ Date of last assessment _____
PPS Scores over last month (if available) _____ _____ _____ _____
Over last _____, oral intake has ☐ Increased ☐ Decreased ☐ No change

Prognosis: ❑ < 1 month ❑ < 3 month ❑ < 6 months
as determined by: Palliative Health Care Practitioner _____

Individual aware of: ❑ Diagnosis ❑ Prognosis ❑ Does not wish to know
Family are aware of: ❑ Diagnosis ❑ Prognosis ❑ Does not wish to know

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

(Patient Name/Label)

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Care Issues (please check all that apply)	☐ Pain & Symptom Control ☐ EOL Care/Death Management ☐ Disease Management ☐ Spiritual Care ☐ Social Work ☐ Psychological ☐ Loss & Grief (legacy work, anticipatory grief work) ☐ Encouraged Advance Care Planning Conversations between patient and Substitute Decision Maker ☐ Reviewed role of Substitute Decision Maker with the patient's SDM	Is there a known patient goal to access medical assistance in dying? ☐ Yes ☐ No If Yes, requires further conversations with receiving sites
Discharge Potential (only applicable for Pain & Symptom management)	Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met Yes ☐ No ☐ What are the barriers for discharge to the previous living arrangements? What are the alternate options? ☐ Patient/SDM are aware that if the symptoms stabilize, discharge planning will proceed. Please provide specific details:	
Special care considerations (please check all that apply and elaborate)	☐ Allergies:	☐ Central line: ☐ IV: ☐ Pain pump:
	☐ Diet: ☐ Tube feed:	☐ Wound: ☐ Drains:
	☐ Hydration ☐ Transfusion	☐ Dialysis Run/day/time: _____ ☐ Peritoneal dialysis ☐ Hemodialysis Dialysis Discontinuation Date: _____ Review by renal team required. Note: Dialysis is not a treatment option for EOL care.
	☐ Oxygen: ☐ Tracheostomy:	☐ Ongoing treatment for symptom relief(Chemo, radiation):
	☐ Cognition/Dementia Issues	☐ Pacemaker ☐ Internal defibrillator Has it been deactivated ☐ Yes ☐ No
	☐ Additional equipment required?	

RELEVANT ATTACHMENTS (please provide the following if not available to the receiving organization electronically)

☐ Most recent/relevant Patient History / Consultation reports ☐ MAR / Home Medication List

☐ Letter of Understanding ☐ Most recent Physician, Nursing, Allied Health Progress Notes

Palliative Care Hospice & In-Patient Letter of Understanding

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
☐ Palliative Care	☐ Grand River hospital- Freeport, Kitchener ☐ Groves Memorial Hospital- Fergus ☐ St. Joseph's Health Centre- Guelph ☐ Hospice Wellington- Guelph ☐ Lisaard House- Cambridge ☐ Innisfree House- Kitchener

I understand this means:

1. I have discussed the requested program with

   _____.
   (Print Name of Referral Source)

2. I fully understand what the program is and what is expected of me as a patient participating in the program.

I authorize the release of my personal and medical information to the requested program.

_____ _____
Signature of Patient/ Substitute Decision Maker Date

_____ _____
Signature of Witness Date

_____ _____
Name of Individual Obtaining Consent Date

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How is Crisis defined?

A patient is considered to be **"In Crisis"** if:

1. Patient and/or caregiver safety is at risk and/or there is a risk that a significant health event and/or challenging end-of-life symptoms cannot be managed in their current setting
2. Patient at risk of requiring ED or acute care admission
3. Community resources have been exhausted and family/ caregivers are unable to cope with the patient's care needs
4. There is a risk that the services required to meet the patient's end-of-life care plan goals may not be available in their current setting
5. Patient at risk of not accessing their preferred place of death (considering recent trajectory of the PPS score).