Phone: 437-290-8063 Fax: (416) 521-3067

Patient Name _____
Health Card Number _____

Palliative Care Common Referral Form – Scarborough Palliative Care

If urgent response is required within 1-2 days, please contact Scarborough Palliative Care at 437-290-8063

This form is for referral to Palliative Care Services in Scarborough. For Home and Community Care services/orders, please complete appropriate Home and Community Care referral form (Request for Assessment, etc).

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 complete this form as thoroughly as possible

Patient current location:

■ Home ☐ Hospital: _____ ☐ Palliative Care Unit: _____ ☐ Other:_____ Anticipated discharge date: _____

Demographics:

Last Name: _____ First Name: _____

Date of birth (DD MM YYYY): _____ Pronouns: _____ Gender: _____

Health Card Number: _____ VC: _____

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

Home Phone: _____ Cell Phone: _____

Primary Language: _____

Preferred Translator name: _____ Relationship: _____ Phone: _____

Family/Informal Caregivers: Provide Power of Attorney (PoA) for Personal Care *(if known)*

PoA Document Available? ☐ Yes ■ No

Name	Relationship	Main Phone	Business/Cell Phone

Reason for Referral:

☐ Goals of Care/Advance Care Planning Conversations ☐ Pain and Symptom management ☐ End-of-Life Care

☐ Other: _____

	Type(s) of Services Requested	Urgency of Response		
☐	**Community Palliative Care Provider** Referral is for: ☐ Consultative Care ☐ Assume Care	☐ 1 to 2 Days	☐ 1 to 2 Weeks	
☐	**Day Hospice**			
☐	**Supportive Care Counselling**			
☐	**In-home Hospice Volunteer**		☐ 1 to 2 Weeks	☐ Future
☐	**Caregiver Support group**			
■	**Grief and Bereavement Support**			
☐	**Inpatient Palliative Care Unit** *(List all units referred):* ☐ Scarborough Health Network – General Hospital ☐ Providence Healthcare – Unity Health ☐ Other (specify)	☐ 1 to 2 Days	☐ 1 to 2 Weeks	☐ Future
☐	**Bryan and Bette Rowntree Palliative Care Clinical Centre Outpatient Palliative Clinic** ☐ in-person appointment requested ☐ virtual (video) appointment requested	☐ 1 to 2 Days	☐ 1 to 2 Weeks	☐ Future
☐	**Home Care Support** *(Complete Home and Community Care Support Services: Request for Assessment Form)*			

Palliative Care Common Referral Form – Scarborough Palliative Care

☐	**Hospice Residence:** ☐ Peter K. Kwok Yee Hong Hospice	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ Future
☐	**Other Service(s):**	☐ 1 to 2 Days ☐ 1 to 2 Weeks ☐ Future

Patient Information

☐ Lives Alone ☐ Smoking in the Home ☐ Pet(s) in the Home (Specify):

Primary Palliative Diagnosis: | Date of Diagnosis: *(dd-mm-yyyy)*

Past Medical History:

Allergies: ☐ Yes ☐ No ☐ Unknown If Yes (Please Specify):

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

Anticipated Prognosis: ☐ hours to days ☐ days to weeks ☐ weeks to short months ☐ 3 to 6 months ☐ 6 to 12 months ☐ Uncertain

Determined By *(Name and Phone Number)*:

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

Discussed With: Individual ☐ Yes ☐ No Family ☐ Yes ☐ No

Please List All Providers and Services Currently Involved *(if known)*: Additional List Attached

	Name	Phone	Reason
Family Physician			
Home and Community Care Support Services			
Community Nursing			
Pharmacy			
Hospice			
Other			

Has Expressed Willingness to Pay for Private Services: ☐ Yes ☐ No ☐ Unknown

Details of Social Situation, Including Any Needs/Concerns of the Family:

Special Care Needs: *(Please Check All that Apply)*

☐ Transfusion ☐ Hydration ☐ Subcutaneous or ☐ Infusion Pump(s) ☐ Total Parenteral 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:

Palliative Care Common Referral Form – Scarborough Palliative Care

Symptom Assessment:

ESAS Score at the Time of Referral: *(Adapted from Edmonton Symptom Assessment System Revised – ESAS-r, Capital Health, Edmonton)*

(Rate Symptoms: 0 = No Symptom, 10 = Worst Symptom Possible)

Pain:	Tiredness:	Nausea:	Depression:	Drowsiness:	Appetite:
Well-Being:	Shortness of Breath:	Anxiety:	Other:		

Date ESAS Completed: *(dd-mm-yyyy)*

Ambulatory/Functional Status: ☐ Full ☐ Homebound ☐ Mainly sit/lie ☐ Bedbound

Activity: ☐ Normal activity ☐ Unable to maintain normal activity ☐ Unable to do most activity ☐ Unable to do any activity

Self-Care: ☐ Independent ☐ Occasional assistance ☐ Considerable assistance needed ☐ Mainly assist ☐ Total care

Intake: ☐ normal ☐ reduced ☐ minimal ☐ sips ☐ mouth care only

Consciousness: ☐ full, alert ☐ confusion ☐ drowsy +/- confusion ☐ unconscious

Any Additional Information:

Application Checklist (*please include the following information*):

☐ Relevant Medical Information Attached (i.e.: lab, diagnostics, consultations, imaging, etc.)

☐ Current Medication List
(Include Complementary Alternative Medications and Over-the-Counter Medications)

☐ Completed Do Not Resuscitate Confirmation (DNR-C) Form ☐ Yes ☐ No

☐ Patient requires Infection Control Precautions (i.e.: COVID/MRSA/VRE/C-DIFF, etc.) ☐ Yes ☐ No
If yes, please specify:

Form Completed By:	**Phone:**	**Fax:**
Professional Designation :		
(Referring) Physician/NP:	**Phone:**	**Fax:**
Provider Billing Number:		
Date of Referral (ddmmyyyy):		