Ontario Health atHome

NSM Common Palliative Referral

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 sections that pertain to your referral (not all sections require completion)

Fax to Ontario Health atHome at 705-797-2401 (1-866-619-5569)

Urgency of Response: ☐ 1 to 2 days ☐ 1 to 2 weeks ☐ Future

NOTE: if urgent response is required within 1-2 days, a phone contact must be made from the service requested

Patient Identification:

Name (surname, first name): _____ Middle Name: _____

HCN: _____ Version: _____

Client #: BRN: Date of Birth (yyyy/mm/dd):

Ontario Health atHomeCare Coordinator (if known):

(Referring) Physician/NP: **Phone:** **Fax:**

Date of Referral: **Patient Identifies as:** ☐ Francophone ☐ First Nation, Inuit, Metis, ☐ Other:

Application Checklist *(*include if available/applicable: Recent Consultation Notes, Communication to the individual's family physician of referral for palliative care services, Copy of completed Do Not Resuscitate Confirmation Form)

☐ Medical Orders attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)

Type(s) of Services Requested

☐ **Community Palliative Care Provider Services**

Referral is for:

☐ Transfer of care to palliative MD/NP

☐ Shared care for palliative approach to care (patient stays rostered with primary care MD/NP where applicable)

☐ Couchiching Only - Transfer to family physician/ NP who accepts palliative patients

☐ **Community Hospice Services**

Specifics:

☐ **Medical Assistance in Dying (MAiD) in the community**

☐ 1st Assessment ☐ 2nd Assessment ☐ Provision

☐ **Ontario Health atHome**

☐ Hospice Palliative Care Nurse Practitioner

☐ Nursing (Complete medical referral form if orders required – link below)

☐ Occupational Therapy

☐ Personal Support Services

☐ Wound Care

☐ Pain symptom management (OHaH CC determines internal/external)

☐ Physiotherapy

☐ Dietician

☐ Social Work

☐ Respiratory Therapy

☐ Speech Therapy

☐ **Pain and Symptom Management Joint Visit Request with NSM HPCN Palliative Pain and Symptom Management Consultant (PPSMC)**

☐ OHaH requesting ☐ Service provider organization requesting ☐ Physician requesting/ ☐ Other requesting attending Requestor name and contact information:

☐ **Hospice Residence – For urgent admissions between 2030-0830 7 days a week fax this referral to selected hospice directly**

PLEASE SELECT HOSPICE RESIDENCE AND/OR ALTERNATE DESTINATION

Alternate Destination (CC only): Where 911 called and patient has a referral for hospice, select 1 in the ranking box for this hospice and select up to 2 additional hospices the patient consents to going if a bed is unavailable at 1st choice.

**Please note alternate destination for 911 calls is currently only available in Simcoe County*

	Ranking	For Care Coordinator to complete		EDITH/SRK
☐		Hospice Georgian Triangle (Campbell House) 705 444 2555 705 446 2229(F) ☐ Respite	SDM/POA: _____ SDM Phone: _____ Nursing Agency: _____ Nursing Agency Phone: _____ Palliative MRP: _____	**FOR HOSPICE/CC USE ONLY** EDITH form in home ☐ yes ☐ no SRK in home ☐ yes ☐ no Funeral Home Chosen: _____
☐	n/a	Hospice Huntsville (Algonquin Grace) 705 789 6878 705 787 0504(F)		
☐		Hospice Huronia (Tomkins House) 705 549 1034 705 549 5366(F)		
☐	n/a	Hospice Muskoka (Andy's House) 705 204 2273 705 646 1609(F)		
☐		Hospice Simcoe 705 722 5995 705 792 9246(F)		
☐		Mariposa House 705 558 2888 705 558 2889(F)		

☐		OHaH Central Hospices **Fax to OHaH Central at** • **416-222-6517 OR 905-9562-2404** **Select Hospice Choice(s) Below:**		
		☐ Hospice Alliston (Matthews House) 705 435 7218 705 435 2755(F)		
		☐ Hospice Alliston - Caregiver Relief Program (Matthews House) 705 435 7218 705 435 2755(F)		
		☐ Hospice Newmarket (Margaret Bahen) 905 967 1500 905 967 1515(F)		
		☐ Hospice Richmond Hill (Hill House) 905 737 9308 647 797 2316(F)		
	☐	Other (specify):		

Is this a direct hospital to hospice referral? ☐ yes ☐ no

Preferred place of death: ☐ Home ☐ Hospice ☐ Other:

Is Hospice backup plan? ☐ yes ☐ no

PATIENT INFORMATION

Home Address: _____

(Street No., Street Name, Building) *(Apt/Suite #)* *(Entry Code)*

City: **Postal Code:**

☐ Lives alone ☐ Young children in the home ☐ Smoking in the home ☐ Pet(s) in the home *(specify)*:

Home Phone Number:	**Alternate Number:**
Gender: ☐ Male ☐ Female ☐ Other:	**Faith/Religion:**
Primary Language(s):	**Translator Name:** _____ **Phone:**

Current Location: ☐ Home ☐ Residential Hospice ☐ Other *(specify address)*:

☐ **Hospital:** _____ **Estimated Date of Discharge:**

(Name of hospital) *(yyyy-mm-dd)*

Primary Palliative Diagnosis: **Date of Diagnosis:**

If Cancer Diagnosis:	**Metastatic Spread:** ☐ yes ☐ no	**Describe:**
	Ongoing Treatment: ☐ yes ☐ no	**Describe:**

Individual Aware of: **Diagnosis:** ☐ yes ☐ no **Prognosis:** ☐ yes ☐ no **Does Not Wish to Know:** ☐ yes ☐ no
Family 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: ☐ Less than 1 month ☐ Less than 3 months ☐ Less than 6 months ☐ Less than 12 months ☐ Uncertain

Determined By *(Name and Phone Number)*:

Functional Status: Palliative Performance Scale (PPS)
PPS: ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Resuscitation Status: Do Not Resuscitate ☐ yes ☐ no ☐ unknown ☐ Form sent home with patient
Discussed with: Individual: ☐ yes ☐ no Family: ☐ yes ☐ no

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

Name	Relationship	Home Phone	Business/Cell Phone

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

	Name	Phone	Fax
Family Physician/NP			
Community Nursing			
Hospice			
Most responsible Palliative Provider			

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

Year *(yyyy-mm-dd)*	Diagnosis	Year *(yyyy-mm-dd)*	Diagnosis

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(Specify Precaution)*:

Required information: As available, reports must be within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.

Allergies: ☐ yes ☐ no ☐ unknown If yes *(please specify)*:

Weight:

Pharmacy (Name and Phone) – if known:

Current Medications: ☐ Medication List Attached

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

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

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

☐ Transfusion ☐ Hydration ☐ Subcutaneous ☐ Intravenous ☐ Infusion Pump(s) ☐ Total Parental Nutrition

☐ Dialysis ☐ Enteral Feeds ☐ Tracheostomy ☐ PortaCath ☐ Central Line(s) ☐ P.I.C.C. Line(s)

☐ Thoracentesis ☐ Paracentesis ☐ Pacemaker ☐ Implanted Cardiac Defibrillator

☐ Oxygen – Rate: _____ ☐ 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:	Anxiety:	Other:		

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

Insurance Information:

Any Additional Information:		
Form Completed by:	**Phone:**	**Fax:**
Professional Designation:		

Signature: