Specialized Palliative Care Services

Resource Package intended for Health Care providers in the Greater City of Sudbury



July, 2024

Health Sciences North
Horizon Santé-Nord

Maison McCulloch Hospice

Ontario Health atHome

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Palliative Care

Palliative Care is an approach to care that aims to improve the quality of life for patients and their families who are facing a life limiting illness. Palliative care does not hasten death, does not prolong dying and is appropriate for all ages. It includes end-of-life care, but is not limited to the time immediately before death.

Palliative Care is required for a wide range of diseases. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. As per the World Health Organization, "Palliative Care is explicitly recognized under the human right to health."

"Limiting the Palliative care approach only to the last few weeks and days deprives patients and families of care that could improve their quality of life and ameliorate suffering."

- *Pallium Canada*

About the Greater Sudbury Specialized Palliative Care Team

The Greater Sudbury Specialized Palliative Care Team works in collaboration with Ontario Health atHome to provide a palliative approach to care, that is delivered by an inter-professional team considering the following:

- A holistic approach to care that is disease agnostic and is initiated early during the course of illness.
- Is comprised of different services that work collaboratively to provide care to each individual during various stages of their disease for a seamless care journey from diagnosis to death.
- Improve access to Palliative Care by providing an integrated specialized Palliative Care consultation for those patients with a prognosis of less than 1 year with goals of care that include a palliative approach.
- Services delivered in person (in a clinic or home setting), via telephone or video conference.
- Management of complex symptoms in the home setting, clinic setting, via admission to a Hospice Short Stay bed, or hospital.
- End-of-Life care in the home setting, Hospice End-of-Life bed, or hospital.
- Other services such as Visiting Hospice and Supportive Care.

Service Providers of the Team: Service Descriptions and Eligibility Criteria

Service	Service Description	Eligibility Criteria
HEALTH SCIENCES NORTH PALLIATIVE CARE UNIT (PCU)	This unit at HSN provides end of life care for patients 17 years of age or older for oncological and non-oncological needs, with a life expectancy of 1 month or less and/or a Palliative Performance Scale (PPS) score of 30% or less.	• 17 years of age or older • Attending physician must have privileges at HSN. • Life expectancy of less than 1 month • Palliative Performance Scale (PPS) of 30% or less • Patients in community who are in a symptom crisis where the intent is the control/alleviation of distressing symptoms and no longer receiving treatment. • Special circumstances may be considered i.e., epidural anesthesia. • Must have DNRC/No Resuscitation order completed.
ONTARIO HEALTH ATHOME	Assesses and provides in home palliative care services for patients with a life expectancy of less than 12 months.	• Life expectancy of 12 months or less • Assesses and determines home palliative care services for patients agreeable to palliative approach to care • Level of support services are determined by utilizing validated tools including the Ontario

		Health atHome – NE assessments, prognosis, PPS, Gold Standard Framework • Must have an address for service provision
MAISON MCCULLOCH HOSPICE COMMUNITY HOSPICE PALLIATIVE CARE TEAM (CHPCT)	Provides medical management and care in the comfort of a patient's home to anyone in the last 12 months of life.	• Non-Oncological patients who may require home visits • Oncological patients who are not able to attend clinics and require home visits. • Must reside or have family who reside in the City of Greater Sudbury • Consultation for non-oncological patients with palliative goals of care and/or unmet palliative needs and a prognosis less than 1 year; and for patients outside of Greater Sudbury
MAISON MCCULLOCH END-OF-LIFE BEDS	Available to patients that require end-of-life care and are in the last 3 months of life.	• Must reside or have family who reside in Greater Sudbury region. • 18 months or older • Life expectancy 3 months or less • Palliative Performance Scale (PPS) 50% or less (PPS should not be used as the sole tool to prognosticate for determination of services). Valid Ontario health card and a patient of Ontario Health atHome • Must have DNRC/No Resuscitation order completed.

MAISON MCCULLOCH HOSPICE SHORT STAY BEDS	Alternate short stay beds for patients in their last 3 months to one year of life requiring a 1 month or less stay for symptom management, caregiver relief or support.	• Patients who have a prognosis of 3 months to 1 year of life, requiring a 1 month or less stay for symptom management, caregiver relief or caregiver support.
		  ○ Has utilized and exhausted in home supports / caregiver requiring caregiver relief.
		  ○ Caregiver requires education to further manage patient at home.
		  ○ Clients require complex symptom management that is not manageable in a home setting.
		• Must reside or have family who reside in Greater Sudbury region.
		• Must have DNRC/No Resuscitation order completed.

	Exclusion Criteria (will be reviewed on a case by case basis): Patients who: • Do not have palliative goals of care (GOC) • Are requesting admission for Medical Assistance in Dying (MAID) provision • Require more than 2 people to transfer or reposition (bariatric patients weighing greater than 275 lbs) • Are currently taking chemotherapy / immunotherapy or who have recently taken chemotherapy treatment (PO, IV, or subcutaneous) requiring precautions beyond universal precautions • Require blood or blood product transfusions • Require or are requesting interventional radiology procedures / radiation • Have not completed an appropriate work-up for a diagnosis and/or prognostication • Are awaiting a Long Term Care (LTC) bed • Require medical interventions beyond the scope of homecare • Have had surgery within 72 hrs or remain unstable post-surgery after 72 hrs	

MAISON MCCULLOCH HOSPICE SUPPORTIVE CARE AND GRIEF SERVICES	Available supportive care, grief and bereavement services for palliative patients in hospice or patients at home.	• Must reside in the City of Greater Sudbury • Life expectancy of 12 months of less • Also offered to client's caregivers / family members
MAISON MCCULLOCH VISITING HOSPICE SERVICES	Available volunteer visits for palliative patients in hospice or at home.	• Must reside in the City of Greater Sudbury • Life expectancy of 12 months or less • Program admission based on volunteer availability • Volunteer visitors do not provide transportation services, personal support services, or other services provided by a regulated and/or certified health care professional, however they do report any pertinent changes in their clients' condition
CITY OF GREATER SUDBURY (CGS) 911 PALLIATIVE PARAMEDIC ROSTER	Paramedics responding to a 911 call for a rostered palliative patient can use a palliative approach to care. This might include using medical directives to treat symptoms such as pain, shortness of breath and anxiety at home, if this is the patient's preference, rather than transporting to hospital. This does not prevent palliative patients from choosing to proceed to hospital at any time during the 911 visit.	• Must reside in the City of Greater Sudbury • Diagnosed with a life-limiting illness at the palliative stage (Service Response Code 95) with Ontario Health atHome • DNR/No Resuscitation in place • Consent and understanding of the service description
SHIRLEY & JIM FIELDING NORTHEAST CANCER CENTRE PALLIATIVE SYMPTOM MANAGEMENT CLINIC (PSMC)	Provides medical management and care in an outpatient clinic setting to address pain and symptom management to patients with a Metastatic Cancer diagnosis.	• Primary Care Practitioner referral • Patient consent and understanding of disease and prognosis. • Cancer diagnosis in the last 12 months of life and requiring a palliative approach to care. • Resides in City of Sudbury • Primary Care Practitioner does not provide palliative care or is requesting a consult. • Able to attend outpatient clinic. Consultation for oncological patients with palliative goals of care and/or unmet palliative needs and a prognosis less than 1 year; and for patients outside of Greater Sudbury

Referral Process

Any of the above services can be accessed by completing the **Sudbury Specialized Palliative Care Team Referral Form**. These forms are available on each inpatient unit at HSN, or by contacting **Ontario Health atHome** or **Maison McCulloch Hospice** (MMH). Please fax the completed referral form to:

Ontario Health atHome - 705-522-3855

For Admitted Patients: you will also be required to enter a "CCAC" referral in Order Management within Expanse, as well as send the resuscitation status and an updated medication list.

For Pediatric Patients (ages 18 months to 18 years)**:** you will also be required to submit a Pediatric Referral form along with the Specialized Palliative Care Team Referral form.

MAID Inquiries

Any inquiries for information about Medical Assistance in Dying can be found at:

https://www.health.gov.on.ca/en/pro/programs/maid/

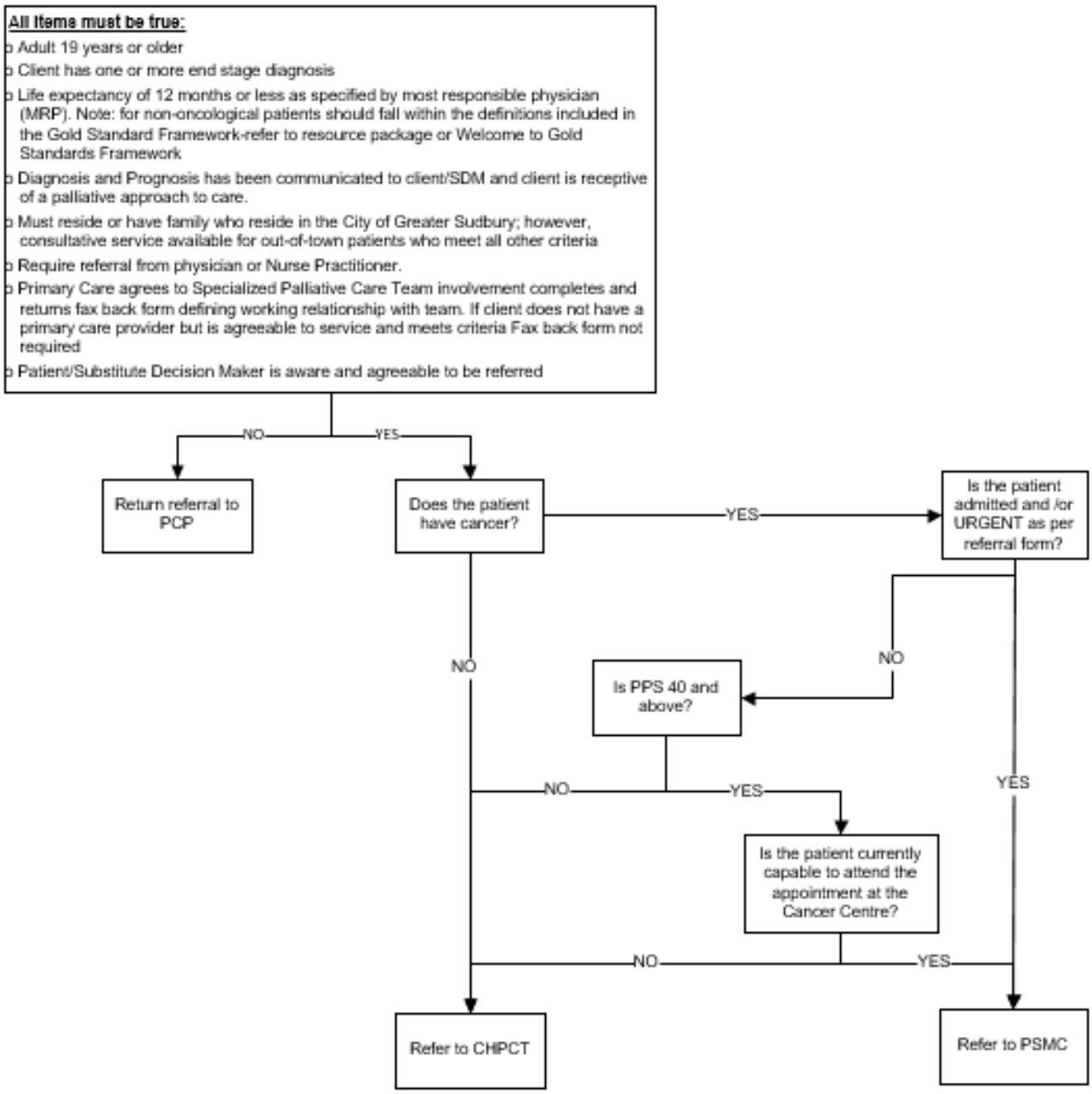
Or by contacting the MAID service information line toll free 24 /7 at 1-866-286-4023.

Referral services for MAID are available Monday – Friday 9am-5pm EST at 1-844-953-3350.

For Admitted Patients: A referral to the MAID Navigator (Order: **Refer to Medical Assistance in Dying (MAID) Navigator)** can be entered by any member of the patient's care team, using the order source **Therapeutic Intervention**. There are tip sheets available on the inpatient units.

Appendix A - Specialized Palliative Care Eligibility Criteria for PSMC and CHPCT*

Specialized Palliative Care
Patient Referral Decision Tree



Appendix B - The Gold Standard framework

The Gold Standard Framework prognostication tool is an evidence-based tool that aids in encouraging early identification, assessment of needs and wishes to help people live well until they die
https://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf

the gold standards framework
4th Edition
October 2011

The GSF Prognostic Indicator Guidance

The National GSF Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life

RCGP Royal College of General Practitioners

Why is it important to identify people nearing the end of life?

'Earlier identification of people nearing the end of their life and inclusion on the register leads to earlier planning and better co-ordinated care'

(GSF National Primary Care Snapshot Audit 2010)

About 1% of the population die each year. Although some deaths are unexpected, many more in fact can be predicted. This is inherently difficult, but if we were better able to predict people in the final year of life, whatever their diagnosis, and include them on a register, there is good evidence that they are more likely to receive well-co-ordinated, high quality care.
This updated fourth edition of the GSF Prognostic Indicator Guidance, supported by the RCGP, aims to help GPs, clinicians and other professionals in earlier identification of those adult patients nearing the end of their life who may need additional support. Once identified, they can be placed on a register such as the GP's QOF / GSF palliative care, hospital flagging system or locality register. This in turn can trigger specific support, such clarifying their particular needs, offering advance care planning discussions prevention of crises admissions and pro-active support to ensure they 'live well until they die'.

Predicting needs rather than exact prognostication. This is more about meeting needs than giving defined timescales. The focus is on anticipating patients' likely needs so that the right care can be provided at the right time. This is more important than working out the exact time remaining and leads to better proactive care in alignment with preferences.

Definition of End of Life Care
General Medical Council, UK 2010

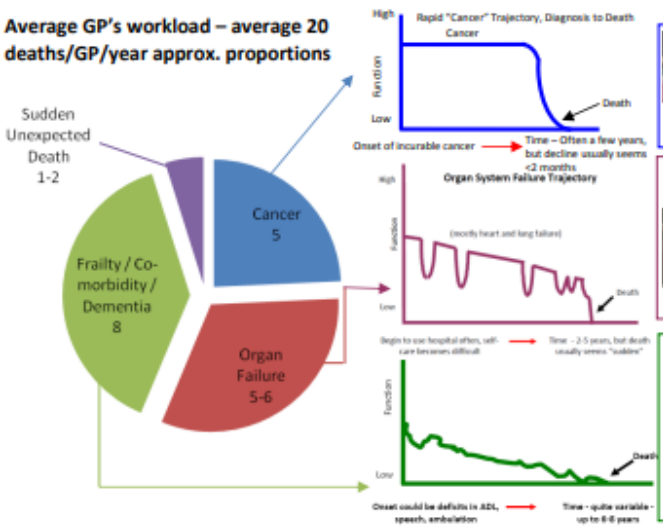
People are 'approaching the end of life' when they are **likely to die within the next 12 months**. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

Three triggers that suggest that patients are nearing the end of life are:

1. **The Surprise Question: 'Would you be surprised if this patient were to die in the next few months, weeks, days'?**
2. **General indicators of decline - deterioration, increasing need or choice for no further active care.**
3. **Specific clinical indicators related to certain conditions.**

Average GP's workload – average 20 deaths/GP/year approx. proportions



Typical Case Histories



1) Mrs A - A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline



2) Mr B – An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline



3) Mrs C – A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'skating on thin ice'. Difficult to predict but likely slow decline

Prognostic Indicator Guidance (PIG) 4th Edition Oct 2011 © The Gold Standards Framework Centre In End of Life Care CIC, Thomas.K et al

Person-Centred Decision-Making: Documenting **Goals of Care** Discussions



Goals of Care (GOC) discussions occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient's goals and values. If there are no current decisions, please see Advance Care Planning resources on the back of this document.

1. Reason for the GOC Discussion?	2. Any concerns about patient's ability to participate in the discussion? Yes ☐ No ☐

☐ Treatment or care decisions to make
☐ Admission/Transfer to a new facility
☐ Code status discussion
☐ Follow up from previous GOC discussions
☐ Information sharing
Other _____
	If Yes:
	• Document concerns if patient is mentally incapable to make decision
	  ○ Engage SDM (patient may still be involved in discussion)
	  ○ For specific treatments, obtain consent from capable patient or SDM
	  ○ See below for SDM Hierarchy and resources
	• Address language or communication barriers

3. Document the GOC Discussion	
Assess understanding: **Explore and listen** **"Tell me in your own words what is happening with your health?"** **"What is your understanding of where things are with your illness"**	Document answers in patient's/SDM's words (e.g. "I know my heart is weak...but I get better each time I come to hospital..."; "I don't know what is wrong..."; "I know I am sick, and I don't know what to expect")
Inform: **Ask permission** **"I need to give you some information that is important to the decisions you need to make, is that ok?"** **"What other information would be helpful to you?"**	Document information you provided to patient/SDM (e.g. patient wishes to hear all information. We discussed the benefits and risks of further treatment – he understands that treatment may prolong his life for weeks to months and that the risks are ...)
Goals & Values: **What matters to your patient? Ask gently:** **"What are you hoping to achieve?** **"What are your most important goals?** **"What are your biggest fears and worries about the future?** **"How much does your family know about your goals and priorities?"**	Document answers in patient's/SDM's words (e.g. "I am hoping to get well enough to go home, walk around the house without help"; "I am hoping to get back to work"; "I am hoping to see my cottage one more time"; "I am worried about pain")
Make a Plan: **Based on goals and values** • **Recommend treatments based on patient goals (or, explain why goals are not achievable)** • **Acquire further input from specialists?** • **Organize further meeting?**	Document next steps (e.g. we will arrange a team meeting with all specialists to discuss possible next steps; we will obtain consent to do a trial of antibiotics and reassess in 3 days; "determined no role for dialysis")

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Acknowledgement: Ariadne Labs' *Serious Illness Conversation Guide* was used in developing both the structure and content

Person-Centred Decision-Making:
Documenting **Goals of Care** Discussions

4. Specific Treatment and Care Preferences

Attempts at Resuscitation in the event of cardio-pulmonary arrest:

Many institutions have specific CPR order sets for documentation. Please use those to documents orders. This list is a guide for discussion of preferences and may be used by institutions without specific order sets to create orders.

- ☐ Full Cardiopulmonary Resuscitation (CPR/Intubation/ICU transfer)
- ☐ Modified resuscitation for respiratory distress : Intubation and mechanical ventilation only NO CPR
- ☐ Allow natural death

For Long Term Care, Complex Continuing Care or Rehabilitation:
Preference for receiving care in current facility or for transfer to acute care

- ☐ Transfer to Acute Care
- ☐ No transfer to Acute Care

**Use this to start a discussion about treatment options available at each facility. Every situation will be different, and a discussion is required before transfer.*

Preferred place of death (if known and appropriate):

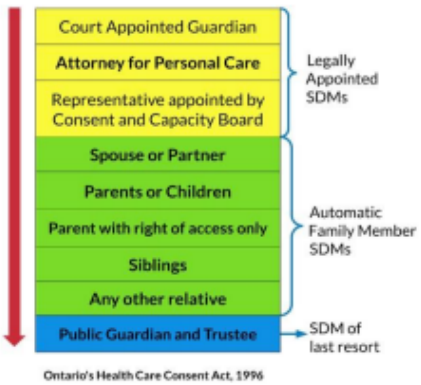
Not all options are available in every location (preference is not always possible and decisions may change as illness progresses)

- ☐ Home
- ☐ Hospice / Palliative Care Unit
- ☐ Long Term Care (includes nursing and residential facilities and Complex Continuing Care)
- ☐ Hospital – acute care facility

Discussion occurred with:

- ☐ Patient: _____
- ☐ SDM(s) [specify name(s) & relationship]: _____ _____ –
- Attach power of attorney document if applicable
- Others present for discussion: _____ _____ –

Signed by: (Health Care Provider)
Print Name: _____
Signature: _____
Professional designation: _____
Date: _____



Ontario's Health Care Consent Act, 1996

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Person-Centred Decision-Making:
Documenting **Goals of Care** Discussions

This represents the process an HCP can use to determine which conversation to have.

The skills and the flow of these conversations are all quite similar. The proximity to health care decisions and the need for specific consent are what moves one along the flowchart.



Advance Care Planning (ACP) differs from Goals of Care (GOC) Discussions. The purpose of ACP is to prepare people and their SDMs for future decision-making. ACP is ***not*** consent for future care. (for more information about how to help patients with ACP, see Speak Up Campaign).

Model of a Goals of Care Discussion



PREPARE yourself

- Start by knowing the available treatments, including the burden of the treatment, its risks and likely benefits
- Think about how you are feeling about the conversation and spend a moment to prepare yourself.
- Next, leave your agenda at the door -- you are there to help a patient make decisions -- not convince them of your decision. Once you have understood their needs, understanding, values and goals, you will be in a better position to use your medical expertise to recommend a plan.

Explore your patient's ILLNESS UNDERSTANDING

- Explore what your patient knows and thinks about her illness and future. This step requires that you listen closely, ask questions to clarify and explore and use empathic reflections to prompt your patient to continue.
- Some patients will seem to have very little illness understanding initially, but with time and gentle enquiry, you will discover that your patient does in fact know a lot about their illness. Achieving a full illness understanding may take several discussions and may require emotional support.
- The most important thing to do is to listen and refrain from speaking – especially when the patient is thinking.
- Even if time is short (emergency decision to be made), spending a few minutes at this step will often provide information that makes all the next steps easier and quicker.



"I'm worried about your father – he is quite ill, and we may have to make some decisions very soon. But before that, tell me what you know about his cancer..."

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Person-Centred Decision-Making:
Documenting **Goals of Care** Discussions

Give INFORMATION if necessary

- Ask for permission to give information
- Give information in short pieces -- one or two sentences at a time and pause frequently to see how the information is being understood and to allow for emotions.
- If possible, provide information that relates to the person's goals
    - How will accepting or refusing the treatment affect what is important to them?

"Does this make sense to you?"

"Is this information new or surprising to you?"

VALUES & GOALS: Ask about goals, values, hopes and fears

- Your work is to help patients uncover their goals. Sometimes, your patient needs your help to express their values, goals and beliefs - through listening, reflecting and clarifying questions.
- Don't worry if the patient's goals are not achievable. It is still their goal and only by knowing it, acknowledging it and discussing it can you help them choose a goal that is within medical reach.

Examples of values and goals
- Attend upcoming family event
- Try a further treatment to reverse underlying illness
- Avoid hospital admission unless for symptom management only
- Get strong enough to walk

Recommend a PLAN that meets those goals

- Recommend a plan based on what you heard about their values and goals.
- This may include proceeding to informed consent for a proposed treatment or the plan may include agreeing to revisit the conversation before moving forward with a treatment plan.
- Note: you are just making just a recommendation. The patient can consider the treatment, reflect on their goals and discuss more fully before making a decision to consent to any treatment or plan.

"Based on what you've told me is important to you, can I suggest a plan going forward?"

Code status and other treatment decisions:

- Even when curative treatments are unavailable, there are many other important treatment decisions that arise in the care of patients. For example, the use of antibiotics, blood transfusions and treatments like chemotherapy/ radiotherapy, dialysis and diuretics can be used for symptom management. The intent of these treatments may also be to delay disease progression.
- Decisions about code status are only one important treatment decision among many.
- GOC discussions may result in a decision to forego attempts at resuscitation, but that is not the sole purpose of a goals of care discussion.

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Appendix D – Advance Care Planning Person-Centered Decision Making Electronic Resources

Person-Centered Decision-Making: Documenting Goals of Care Discussions: https://www.rgptoronto.ca/wp-content/uploads/2020/06/Person-Centred-Decision-Making-Documenting-Goals-of-Care-Discussions.pdf

Clinician Guide: https://www.pcdm.ca/HPCO/Assets/Documents/PDFs/ACP-Conversation-Guide-Clinician-Primer-1.pdf

Patient workbook: https://advancecareplanningontario.ca/acp/acp-workbook

Advance Care Planning Ontario:

https://advancecareplanningontario.ca for patient and families Understanding Advance Care Planning (ACP) in Ontario: Prepare for Future Healthcare Decisions (advancecareplanningontario.ca)

https://www.pcdm.ca for health care providers Welcome to HPCO's Online Learning Portal (pcdm.ca)

Appendix E – Palliative Performance Scale (PPS)

BCGuidelines.ca
Guidelines & Protocols Advisory Committee

Appendix A: Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Occasional assistance required	Normal or reduced	Full or confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or coma +/- confusion
0%	Death	—	—	—	—

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Appendix F – Sudbury Specialized Palliative Care Team Referral

Shirley and Jim Fielding Northeast Cancer Centre
Centre de cancérologie du Nord-Est Shirley et Jim Fielding

Ontario Health atHome

Maison McCulloch Hospice

SUDBURY SPECIALIZED PALLIATIVE CARE TEAM REFERRAL

Fax referral to Ontario Health atHome North East: 705-522-3855

BOLD FIELDS ARE MANDATORY

SECTION A – ELIGIBILITY CRITERIA

☐ **Patient meets eligibility criteria**

- **Life expectancy of 12 months or less.** *NOTE: non-oncological patients should fall within the definitions included in the Gold Standard Framework*
- **Client consents to referral to Palliative Care**
- **Adult 19 years or older**
- **Resides or has family who reside in the City of Greater Sudbury.** *NOTE: Consultative service available for out-of-town patients who meet all other criteria*
- **Require referral from Physician or Nurse Practitioner**
- **Pediatric End of Life Beds: 18 months to 18 years old**

SECTION B – GENERAL INFORMATION

Name: _____ **DOB(yyyy/mm/dd):** _____ **Age:** ____ **Gender:** _____
Phone: _____ **Address:** _____
City: _____ **Province:** _____ **Postal Code:** _____
Ontario Health Card #: _____ **Version Code:** _____
Family Physician/NP: _____ Preferred Language: ☐ English ☐ French ☐ Other:
Marital Status: _____ Lives Alone: ☐Yes ☐No Present location of client: ☐ Home ☐ Hospital Unit ☐ Unknown
Primary Contact, if other than patient: Name: _____ Phone: _____
Relationship: _____
SDM or POA if different than primary contact: ☐Yes ☐No ☐N/A Name: _____ Phone: _____
Relationship: _____

SECTION C – DIAGNOSIS & PROGNOSIS ESTIMATION

End stage diagnosis/diagnoses (*Please include any relevant reports not available in EMR*):
_____
Date of Diagnosis/Prognosis (yyyy/mm/dd): _____ ☐ Oncological ☐ Non-Oncological
Client able to attend outpatient clinic? ☐ Yes ☐ No **PPS:** _____ **%**
Prognosis is: ☐ Less than 12 months ☐ Less than 6 months ☐ Less than 3 months ☐ Less than 1 month
Client aware of diagnosis and prognosis? ☐Yes ☐No Family aware of diagnosis and prognosis? ☐Yes ☐No

SECTION D – SERVICE(S) REQUESTED (*Please refer to resource package for description of services*)

☐ URGENT (please explain): _____
***Mandatory to call:** Oncology (Palliative Physician On-Call: 705-523-7100 x1100) or Non-Oncology/Hospice (CHPCT: 705-586-2273)
Case discussed with: _____
☐ MD or NP Specialist Palliative Care Consultation: CHPCT / PSMC
If HSN discharging to home – indicate MRP in community for Palliative coverage (Name/Phone): _____
☐ Residential Hospice End-of-Life Bed (Prognosis 3 months or less): MMH
☐ Pediatric EOL Bed: **Pediatric Referral form completed**
☐ Residential Hospice Alternate Care Bed (Prognosis 3-12 months): MMH
☐ Grief and Bereavement Service: MMH Supportive Care Program
☐ Visiting Volunteer: MMH Visiting Hospice Services
☐ Home Care Services (ie. Nursing, PSW etc.): Ontario Health atHome

Additional Notes:

SECTION E – GOALS OF CARE

Goals of care discussed with referring provider: ☐Yes ☐No Patient agreeable to palliative approach to care: ☐Yes ☐No
No Resuscitation Status (DNR): ☐Yes ☐No An in-home pronouncement is in place: ☐Yes ☐No
Preferred place of death: ☐ Home ☐ Hospice ☐ Hospital Patient Requires Symptom Relief Kit: ☐Yes (order required) ☐No

SECTION F – REFERRAL INFORMATION

Referring Provider (please print)	Organization	Phone
Name of individual completing form (if not referring Provider		Date(yyyy/mm/dd)

For MAID request please contact Ontario MAID Care Coordination Service: 1-866-286-4023
For HSN PCU Bed requests please call 705-675-4755

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