Ontario Health atHome

CLEAR

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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 the 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: DOB (yyyy/mm/dd):

Ontario Health atHome Care Coordinator (if known):

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

Date of Referral: **Patient Identifies as:** ☐ Francophone ☐ First Nation, Inuit, Métis ☐ 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 of 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)
- ☐ 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
- ☐ Physician requesting/attending
- ☐ Service provider organization requesting
- ☐ Other

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 F: 705-446-2229 ☐ Respite	SDM/POA:	**FOR HOSPICE/CC USE ONLY**
	☐	n/a	Hospice Huntsville (Algonquin Grace) 705-789-6878 F: 705-787-0504	SDM Phone:	EDITH form in home ☐ yes ☐ no
	☐		Hospice Huronia (Tomkins House) 705-549-1034 F: 705-549-5366	Nursing Agency:	SRK in home ☐ yes ☐ no
	☐	n/a	Hospice Muskoka (Andy's House) 705-204-2273 F: 705-646-1609	Nursing Agency Phone:	
	☐		Hospice Simcoe 705-722-5995 F: 705-792-9246	Palliative MRP:	Funeral Home Chosen:
	☐		Mariposa House 705-558-2888 F: 705-558-2889		
	☐		OHaH Central Hospices **Fax to OHaH Central at** **416-222-6517 OR 905-952-2404** **Select Hospice choice(s) below:**		
			☐ Hospice Alliston (Matthews House) 705-435-7218 F:705-435-2755		
			☐ Hospice Alliston – Caregiver Relief Program (Matthews House) 705-435-7218 F: 705-435-2755		
			☐ Hospice Newmarket (Margaret Bahen) 905-967-1500 F: 905-967-1515		
			☐ Hospice Richmond Hill (Hill House) 905-737-9308 F: 647-797-2316		
	☐		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 ☐ Pets 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)*

Details:

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**

Previous 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: ☐ unknown ☐ no ☐ yes *(please specify)*

Weight:

Pharmacy (Name and Phone) – *if known*:

Current Medications: ☐ Medication List Attached

Medication Details:

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 Parenteral 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	Specify:	
☐	None		

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: Anxiety:
Drowsiness: Appetite: Well-Being: Shortness of Breath:
Other Symptoms:

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

Any Additional Information:

Form Completed by:
Signature: _____ **Designation:** _____ **Date:** _____

Phone: _____ **Fax:** _____