

PALLIATIVE CARE REFERRAL

FAX: 613-756-0106

PHONE: 613-756-3045 ext. 350

Please contact MVH at the number above prior to submitting referral for Hospice Admission

CLIENT INFORMATION

Surname <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Given Name	Age	DOB yy/mm/dd	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Address Postal Code		City	Prov.	Phone Number	

Current Location: Home SFMH VM WTL Room # _____ Other _____

Ontario Health Card No.	Version Code	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other:
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Client is aware, agreeable and consents to referral and sharing of health information? Yes If no, unable to proceed with referral.

FAMILY PHYSICIAN

Name:	Phone:	Fax:
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REASONS FOR REFERRAL (Please check all that apply)

Diagnosis: _____ ALLERGIES: _____

Caregiver Stress Function and Support Urgent End-of-Life Assist Advance Care Planning Hospice Admission
 Bereavement Support Other:

Check if referral is urgent; What issues make this referral urgent?

SIGNIFICANT MEDICAL HISTORY (including recent changes)

1	2	3
4	5	6

Current Functional Status at time of referral: Palliative Performance Scale

PPS: 10% ___ 20% ___ 30% ___ 40% ___ 50% ___ 60% ___ 70% ___ 80% ___ 90% ___ 100% ___

YOUR GOALS AND EXPECTATIONS FOR HOSPICE to ACCOMPLISH

ALTERNATE CONTACT PERSON INFORMATION

Name:		Relationship of Client:	
Phone: Home:	Work:	Cell:	Email:

Who should be contacted for appointment? Client Other:

REFERRAL SOURCE

Name:	Relationship to Client	Phone/Ext.	Fax:
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Printed Name	Signature	Referral Date yyyy/mm/dd
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