

TO ALL PALLIATIVE CARE PROVIDERS

(For the purpose of this Form, an individual refers to a patient and/or client)

Please complete this form¹ as thoroughly as possible. Each referring agency, group or institution should decide which practitioner(s) is most appropriate to complete each section. The CCAC "placement application form" no longer needs to accompany the Palliative Care Common Referral Form.

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.

If this is being used to refer to a palliative care inpatient facility

When the individual is ready for transfer to a palliative care facility, please contact the unit directly. Include the most recent clinical update and medication list and identify any special needs such as special mattresses or other surfaces required, nephrostomy tubes, chest tubes, intravenous access devices or infusion pumps, etc. in the transfer information package (refer to Page 4). Please note that **resuscitation is not offered** as part of the admission criteria for in-patient palliative care and residential hospice care. Definition of Cardiopulmonary Resuscitation (CPR) by Ministry of Health and Long-Term Care (MOHLTC) - is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardiorespiratory arrest. These measures include basic cardiac life support involving chest compressions, and/or artificial ventilation e.g. mouth-to-mouth resuscitation, bagging, and where available, defibrillation, intubation and other procedures considered to be Advanced Cardiac Life Support procedures by the Heart and Stroke Foundation of Ontario.

Application Checklist (include if available):

- Care protocols attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)
- Communication to the individual's family physician of referral for palliative care services
- Copy of completed Do Not Resuscitate Confirmation Form
- Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) Recent chest x-ray
- Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) **As available, reports must be current within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.**
- Recent consultation notes Recent laboratory results Pathology reports

Please complete thoroughly and PRINT clearly. The following pages contain the referral form:

Page 1-2: Demographic information, reason for referral, diagnosis, prognosis, resuscitation status, services requested and urgency of services requested.

Page 3-4: Current care needs, symptom management needs and functional status, psychosocial and spiritual support needs, goals of care discussions.

Page 5: Referral for Community Care Access Centre. Please ensure prescriber's signature is included where orders are given (eg. Most Responsible Physician or Nurse Practitioner).

Last page: The updated information sheet is used for updated reports to health care team members who are currently providing palliative care services to the individual. This page does not need to be included for new referrals.

¹The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered.
Last modified April 1, 2010

Date of referral: (DD/MM/YY): _____

Individual's Last Name: _____ First Name: _____

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

Lives Alone Young Children in the Home Smoking in the Home Pet in the Home (specify): _____

Home phone number: () _____ - _____ Alternate number: () _____ - _____

Date of birth: (DD/MM/YY) _____ Gender: _____ Faith/Religion: _____

Health card number: _____ - _____ - _____ Version code: _____

Primary contact person (name/relationship/phone number): _____

Primary language(s): _____ Translator: (name/phone number): _____

Current location: Home Residential hospice Other (specify address): _____

Hospital _____ Anticipated hospital discharge date: _____

Primary palliative diagnosis: _____ Date of Diagnosis: _____

Other relevant diagnosis related to reason for referral: _____

If cancer diagnosis, metastatic spread: Yes No Describe: _____

Reason for referral: Assessment for Services Activities of Daily Living Instrumental A.D.L.

Individual does not wish to die at home Planned death at home Psychosocial Support

Respite/Support for caregiver Other (specify) _____

Symptom management (specify): _____

Anticipated prognosis: < 1 month < 3 months < 6 months < 12 months Uncertain

Determined by (name and phone number): _____

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 is not aware, individual has given consent to inform Family of: Diagnosis Yes No Prognosis Yes No

Resuscitation status: Do Not Resuscitate Yes No Discussed with: Individual Yes No Family Yes No

Do Not Resuscitate Confirmation Form Completed and given to individual/family: Yes No

Type(s) of services requested	Urgency of response
<input type="checkbox"/> Community Care Access Centre (complete CCAC Medical Referral Form):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks
<input type="checkbox"/> Community Palliative Care Physician (Specify Palliative Physician Team): Referral is for: <input type="checkbox"/> Consultative care <input type="checkbox"/> Primary care	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks
<input type="checkbox"/> Hospice Program: <input type="checkbox"/> Home Visiting <input type="checkbox"/> Day Program <input type="checkbox"/> Residential Hospice (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future <input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future
<input type="checkbox"/> Inpatient Palliative Care Unit (List all units referred):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future
<input type="checkbox"/> LHIN-specific Palliative Care Community Team (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks
<input type="checkbox"/> Palliative Pain & Symptom Management Consultant (PPSMC)	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 1 - 2 weeks <input type="checkbox"/> Future

Note: Referral Source must be responsible to send referral to all services requested as indicated above; If urgency request is within 1-2 days, a phone contact must be made to the service requested

Individual's Last Name: _____ **First Name:** _____

Please list all Providers and Services currently involved: Additional list attached

Name	Phone	Fax
Family Physician: <input type="checkbox"/> Yes <input type="checkbox"/> No Notified of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Home visits: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Family/Informal Caregivers: ² The *Health Care Consent Act 1996*, c. 2, Sched. A, s. 4 (1), states "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision".

Name	Relationship	Home Phone	Business/Cell Phone
Power of Attorney (POA) for Personal Care ² : <input type="checkbox"/> Documentation attached			
If no POA, substitute decision maker according to the legislated hierarchy:			

Health History: Check here if documentation is attached

Year	Diagnosis	Year	Diagnosis

If cancer diagnosis: Prior treatment for symptom relief: Surgery (Specify and Date) _____

Radiotherapy Date: _____ Chemotherapy Date: _____ Other: _____ Date: _____

Allergies: Yes No Unknown If Yes (please specify): _____

Current medications: medication list attached **Pharmacy** (name and number): _____

(Include complementary alternative medications and over-the-counter medications)

Approximate Height: _____ Approximate Weight: _____

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

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Individual's Last Name: _____ First Name: _____

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): _____ **Date ESAS completed:** _____

Pain _____ Tiredness _____ Nausea _____ Depression _____ Anxiety _____ Drowsiness _____
 Appetite _____ Well-being _____ Shortness of breath _____ Other: _____

Symptom(s) most distressing to the individual: _____

Current care needs: (please check all that apply)

- Transfusion Hydration: SC or IV Infusion pump(s) Total Parental Nutrition Enteral feeds
- Dialysis Central line(s) P.I.C.C. line(s) PortaCath Tracheostomy
- Oxygen: rate: _____ Thoracentesis Paracentesis Drains/Catheter (specify): _____
- Ostomy care Urinary catheter Pressure ulcer(s) (specify location and stage): _____
- Wound care (specify): _____
- Therapeutic surface (specify): _____
- Other needs: _____

Infection Control: MRSA/VRE (+) C-DIFF (+) Other (specify precaution): _____

Symptom Management Kit in the home? Yes No Not Known

If cancer diagnosis: Ongoing treatment for symptom relief: Surgery (date and specify): _____

Radiotherapy: Last treatment date and site/area: _____

Chemotherapy: Last treatment date: _____ Oral chemotherapy: Yes No Name: _____

Functional status: Palliative Performance Scale (PPS): refer to Victoria Hospice Society, PPSv2, Cancer Care Ontario for definition

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

Mobility: Ambulatory Ambulatory with aid Ambulatory with people Bed-ridden

Cognition: Alert Altered Cognition Responsive to Stimuli Unresponsive

Bathing: Independent With assistance Total assist

Feeding: Independent With assistance Total assist NPO

Difficulty swallowing (describe): _____

Diet Type: _____ Diet Texture: _____ Other: _____

Bowel function: Continent Incontinent Constipation: Yes No Last BM: _____ Diarrhea: Yes No Freq: _____

Bladder function: Continent Incontinent Catheter

Other Needs: Vision impaired Hearing impaired Speech impaired

Behaviour (describe): _____

Psychosocial and Spiritual status and concerns:

Issue	Yes	No	Unknown	Description
Spiritual Distress				
Financial Concerns				
Past Substance Use				
Current Substance Use				
Other				

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Individual's Last Name: _____ **First Name:** _____

Insurance information (if known): _____

Has expressed willingness to pay for private services: Yes No Not Known

For inpatient palliative care units: Co-payment fees reviewed (where appropriate)

Semi-private accommodation requested Private accommodation requested

Details of social situation, including any needs/concerns of the family:

Any additional information appropriate, including individual's goals of care:

Referral Source:

Name & Discipline: _____ **Tel.:** _____ **Fax:** _____

(Referring) Physician: _____ **Tel.:** _____ **Fax:** _____

Billing Number: _____

Form completed by (*print/signature*): _____ **Date:** _____

Telephone and pager number (if different from referral source): _____

Individual's Last Name: _____ First Name: _____

PLEASE COMPLETE THIS SECTION OF THE FORM FOR ANY REFERRAL TO CCAC AND INCLUDE PAGES 1-4 WITH THIS REFERRAL

(Treatments will be taught/reduced unless otherwise indicated)

Service requested:		Prescriber's Orders:
Nursing	<input type="checkbox"/>	
Dietician	<input type="checkbox"/>	
Occupational therapy	<input type="checkbox"/>	
Personal support	<input type="checkbox"/>	
Physiotherapy	<input type="checkbox"/>	
Social work	<input type="checkbox"/>	
Speech therapy	<input type="checkbox"/>	
Laboratory tests (Where Applicable)	<input type="checkbox"/>	
Other (specify):	<input type="checkbox"/>	
Signature of Prescriber: _____		Designation: _____

Medical Supervision while on CCAC services

Referring Physician (Attending): _____	Most Responsible Physician: _____ <input type="checkbox"/> Check if same as Attending Physician
Staff physician's name (if applicable):	Name:
Name:	Address:
Address:	Office phone number:
Phone number:	After hours phone number:
Specialty:	Fax number:
OHIP billing code:	Specialty:
Signature:	OHIP billing code:
Signature date:	Has this physician been contacted and agrees: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Contacted by:
	Date of contact:
	Date of next medical appointment:

PALLIATIVE CARE COMMON REFERRAL FORM UPDATE/REPORT:

Individual's Last Name: _____ First Name: _____

Health card number: _____ - _____ - _____ Version code: _____

Date of birth: (DD/MM/YY) _____

Current location: Home Residential hospice Other (Specify address): _____

Hospital _____ Anticipated hospital discharge date: _____

Home Address: _____ Postal code: _____

Home phone number: () _____ - _____ Alternate number: () _____ - _____

Resuscitation Status (if different from original referral):

Do Not Resuscitate Yes No **Discussed with:** Individual Yes No Family Yes No

ESAS Score at the time of this updated referral:

(Adapted from Edmonton Symptom Assessment System—ESAS, Capital Health, Edmonton) 0–10: (0 = no symptom, 10 = worst symptom possible): **Date completed:** _____

Pain _____ Tiredness _____ Nausea _____ Depression _____ Anxiety _____ Drowsiness _____

Appetite _____ Well-being _____ Shortness of breath _____ Other: _____

Current Functional status:

Palliative Performance Scale (PPS) at time of referral (refer to Victoria Hospice Society, PPSv2/ Cancer Care Ontario for definition).

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

List Current Medications (if different from original referral):

Current Infection Control Management Reports/Updates (if different from original referral):

Additional Notes / Updates:

Completed By: Print Name: _____ Signature: _____

Telephone & Pager: _____

Date of this update: _____