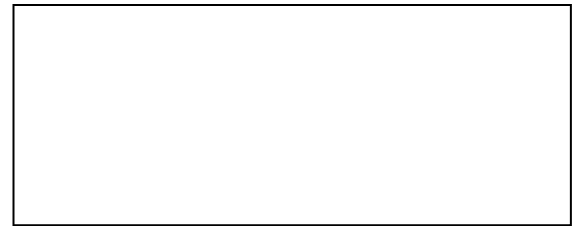

TORONTO CENTRAL PALLIATIVE CARE NETWORK

- Palliative Care Common Referral Form

TO ALL PALLIATIVE CARE PROVIDERS

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

Please complete this form[1] 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 3). 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.

[1] The 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
❑ Community Care Access Centre (complete CCAC Medical Referral Form):	❑ 1-2 days ❑ 1 - 2 weeks
❑ Community Palliative Care Physician (Specify Palliative Physician Team): Referral is for: ❑ Consultative care ❑ Primary care	❑ 1-2 days ❑ 1 - 2 weeks
❑ Hospice Program: ❑ Home Visiting ❑ Day Program ❑ Residential Hospice (specify):	❑ 1-2 days ❑ 1 - 2 weeks ❑ Future ❑ 1-2 days ❑ 1 - 2 weeks ❑ Future
❑ Inpatient Palliative Care Unit (List all units referred):	❑ 1-2 days ❑ 1 - 2 weeks ❑ Future
❑ LHIN-specific Palliative Care Community Team (specify):	❑ 1-2 days ❑ 1 - 2 weeks
❑ Palliative Pain & Symptom Management Consultant (PPSMC)	❑ 1-2 days ❑ 1 - 2 weeks
❑ Other (specify):	❑ 1-2 days ❑ 1 - 2 weeks ❑ 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***

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Individual's Last Name: ________________ ____________________ **First Name:** ____________________

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

Name	Phone	Fax
Family Physician: ❑ Yes ❑ No Notified of referral: ❑ Yes ❑ No Home visits: ❑ Yes ❑ 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]: ❑ 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): ____

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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	❑	
Dietician	❑	
Occupational therapy	❑	
Personal support	❑	
Physiotherapy	❑	
Social work	❑	
Speech therapy	❑	
Laboratory tests (Where Applicable)	❑	Type(s) and frequency: __________ Report results to: __________ Start date: ________ / ________ / ________
Other (specify):	❑	
Signature of Prescriber:		**Designation**:

Medical Supervision while on CCAC services	
Referring Physician (Attending): __________________	**Most Responsible Physician: __________________** ❑ **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: ❑ Yes ❑ No
	Contacted by:
	Date of contact:
	Date of next medical appointment:

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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: ___________________________________

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