South West **LHIN**

South West LHIN Hospice Residence Referral Form *(Use numerical values for hospice of choice eg. 1, 2, 3)*

0 **Chapman House**	0 **Sakura House**	0 **Huron Hospice**	0 **Rotary Hospice Stratford Perth**	0 **St. Joseph's Hospice**	0 **Parkwood PC Unit**	0 **Jessica's House**

Priority: ☐ **Urgent (within 24 hours, A)** ☐ **Non-urgent (B, C)** ☐ **Pre-register for future admission (E)**

The lettering A, B, C, E are related to the Priority Tool used in some subregions

DATE OF REFERRAL (yyyy/mm/dd): Click to Clear Form ◯

PATIENT'S PERSONAL INFORMATION

Last Name	First Name		Date of Birth (yyyy/mm/dd)
Address	Apt #	City/Province	Postal Code
Home Telephone	Preferred Language	Gender	Height Weight
Health Card Number and Version Code		BRN # (community)	PIN# (as applicable)
Primary Care Provider (PCP):	Phone:	Fax:	Is PCP aware of referral: ☐ Yes ☐ No

MRP in Hospice: ☐ Primary Care Provider ☐ Hospice Physician

Office #: Alternate Contact #: Fax #:

REFERRAL SOURCE

Primary Clinical Contact/LHIN CC: Phone #: Pager #:

Caseload: Patient's Present Location:

Resuscitation/End of Life Care Plan: **DNRc in place** ☐ **DNRc not in place** ☐

HEALTH CARE DECISION MAKING/SUBSTITUTE DECISION MAKER(SDM) (if more than 2 SDMs indicate in Additional Comments Section Below)

Automatic SDM (based on hierarchy) ☐ **Power of Attorney for Personal Care (documented)** ☐

Name: Phone #

Name: Phone #

CLINICAL INFORMATION

Primary diagnosis: Secondary diagnosis:

Palliative Performance Scale (PPS) Date PPS completed:

Anticipated prognosis: ☐ < 1 week ☐ < 1 month ☐ < 3 months ☐ < 6 months As assessed by:

Edmonton Symptom Assessment System (ESAS) score <u>at time of referral</u> (rate 0 = none to 10 = worst)

Pain	Tiredness	Drowsiness	Nausea	Appetite	SOB	Depression	Anxiety	Wellbeing
0	0	0	0	0	0	0	0	0

Current Pharmacy/Phone Additional Coverage ☐ Yes ☐ No Allergies

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CURRENT CARE / EQUIPMENT NEEDS

☐ Transfusion ☐ Hydration ☐ PICC Line ☐ Infusion Pumps ☐ Central Line(s)
☐ Wound Care ☐ Wound Care Orders:

☐ IV ☐ SC	☐ Enteral Feeds ☐ ADP Completed	☐ Tracheostomy ☐ ADP Completed	☐ Ostomy ☐ ADP Completed	☐ Dialysis ☐ Pacemaker/ICD

ICD Deactivated? ☐ Yes ☐ No

☐ Spinal Analgesia ☐ Thoracentesis ☐ Paracentesis ☐ Foley

Ventilation: ☐ CPap ☐ BiPap ☐ invasive ☐ Equipment Rented ☐ Owned

Oxygen rate: ☐

☐ Chest Tube/Pleurex

☐ VRE ☐ MRSA ☐ ESBL ☐ cDiff

Ongoing Treatment: ☐ Radiation ☐ Chemotherapy
Patient/Family will be responsible for transportation from hospice to appointments
Purpose of Treatment: ☐ Life Extending ☐ Comfort Measures ☐ N/A

Antibiotics: ☐ Oral ☐ IV

Other needs (e.g. bariatric):

Assistance needed for transfers and mobility including gait aids:

Therapeutic Surface:

Additional Information: smoker, substance abuse; please comment on any relevant social information):
MAiD Discussion/Consideration: ☐ Yes ☐ No

Financial assistance for transportation anticipated:(name of hospice that offers support) ☐ Yes ☐ No

PATIENT'S GOALS

Form completed by:	Role/title:	Signature:

SUPPORTING DOCUMENTATION to be sent with referral - Please send/fax Admission History, Consult Reports, Recent Progress Notes (CHRIS notes, Local Intake Assessment), Current Medication List and if applicable Wound Care Plan & Behaviour Management Plan. **For Hospice/Parkwood - Most Recent MRP Notes & Care Coordinator Updates. If admission to Parkwood PCU is urgent, fax supporting document directly to PCU as well as to the LHIN. PCU fax # 519 685 4804.
Additional comments: