Phone: 437-290-8063 Fax: (416) 521-3067

Patient Name:
Health Card Number:

Palliative Care Common Referral Form – Scarborough Palliative Care

If urgent response is required within 1-2 days, please contact Scarborough Palliative Care at 437-290-8063

This form is for referral to Palliative Care Services in Scarborough. For Ontario Health atHome services/orders, please complete appropriate Ontario Health atHome referral form (Request for Assessment, etc.)

By submitting this form, you confirm that you have obtained the necessary permissions to release the contained information to the relevant agencies and services.

Please complete this form as thoroughly as possible

Patient current location:

☐ Home ☐ Hospital: _____ ☐ Palliative Care Unit: _____ ☐ Other: _____ Anticipated discharge date: _____

☐ Long-term Care: _____ Unit: _____ Phone: _____

Demographics:

Last Name: _____ First Name: _____

Date of birth (DD MM YYYY): _____ Pronouns: _____ Gender: _____

Health Card Number: _____ VC: _____ ☐ None

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

Home Phone: _____ Cell Phone: _____

☐ Lives Alone ☐ Smoking in the Home ☐ Pet(s) in the Home (Specify): _____

Primary Language: _____ Preferred Translator name: _____

Relationship: _____ Phone: _____

Family/Informal Caregivers: Provide Power of Attorney (PoA) for Personal Care/Substitute Decision Maker (SDM)

PoA Document Available? ☐ Yes ☐ No

Name	Relationship	Main Phone	Business/Cell Phone

Reason for Referral:

☐ Goals of Care/Advance Care Planning Conversations ☐ End-of-Life Care

☐ Pain and Symptom management – Specify: _____

_____

☐ Other: _____

	Type(s) of Services Requested	Urgency of Response
☐	**Community Palliative Care Provider** Referral is for: ☐ Consult only ☐ Assume Care	☐ Urgent 1 to 2 Days ☐ Semi Urgent 1 to 2 Weeks ☐ Routine 2+ Weeks
☐	**Day Hospice**	☐ Semi Urgent 1 to 2 Weeks ☐ Routine 2+ Weeks
☐	**Supportive Care Counselling**	
☐	**In-home Hospice Volunteer**	
☐	**Caregiver Support group**	
☐	**Grief and Bereavement Support**	
☐	**Bryan and Bette Rowntree Palliative Care Clinical Centre Outpatient Palliative Clinic** **Please note: First visit will be in-person*	☐ Urgent 1 to 2 Days ☐ Semi Urgent 1 to 2 Weeks ☐ Routine 2+ Weeks

Palliative Care Common Referral Form – Scarborough Palliative Care

☐	**Hospice Residence:** ☐ Peter K. Kwok Yee Hong Hospice	☐ Urgent 1 to 2 Days ☐ Semi Urgent 1 to 2 Weeks ☐ Routine 2+ Weeks

Patient Information

Diagnosis:	Date of Diagnosis:

Allergies: ☐ Yes ☐ No ☐ Unknown If Yes (Please Specify):

Individual Aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does Not Wish to Know: ☐ Yes ☐ No

Family is aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does Not Wish to Know: ☐ Yes ☐ No

If family not aware, individual has given consent to inform family of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No

Anticipated Prognosis: ☐ hours to days ☐ days to weeks ☐ weeks to short months ☐ 3 to 6 months ☐ 6 to 12 months ☐ Uncertain

Determined By *(Name and Phone Number)*:

Resuscitation Status: Do Not Resuscitate ☐ Yes ☐ No ☐ Unknown (Please attach Completed Do Not Resuscitate Confirmation form to the Referral)

Ambulatory/Functional Status: ☐ Full ☐ Homebound ☐ Mainly sit/lie ☐ Bedbound Current PPS:_____

Additional Information (Please free text if patient has any wounds, lines, or care needs):

Please List All Providers and Services Currently Involved *(if known)*: ☐ Additional List Attached

	Name	Phone
Family Physician		
Ontario Health atHome Support Services		
Community Nursing		
Pharmacy		
Hospice		
Other		

Application Checklist (*please include the following information*):

☐ Relevant Medical Information Attached (i.e.: lab, diagnostics, consultations, imaging, past medical history, etc.)

☐ Current Medication List *(Include Complementary Alternative Medications and Over-the-Counter Medications)*

☐ Patient requires Infection Control Precautions (COVID/MRSA/VRE/C-DIFF, etc.) ☐ No ☐ Yes, Specify: _____

Form Completed By:	**Phone:**	**Fax:**
Professional Designation:		
(Referring) Physician/NP:	**Phone:**	**Fax:**
Referring Provider registered with SCOPE	☐ Yes ☐ No	
Provider Billing Number:		
Date of Referral (DD/MM/YYYY):		

PRINT RESET