

Palliative Care Hospice and In-Patient Referral

Date of Application:		Date of Admission:		BRN:	
Personal Information					
Last Name:			First Name:		
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex			
Gender: <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/> I prefer to identify as: _____					
Pronoun patient identifies with (e.g.: he, she, they, ze): _____					
Address		Unit #	City	Prov.	Postal Code
Home Telephone		Present Location (home, hospital, LTC, ED)			
Family Physician/Primary Care Practitioner			Phone	Fax	
Most Responsible Physician			Phone	Fax	
Nurse Practitioner			Phone	Fax	
Health Insurance Information					
Is patient covered under Ontario Health Insurance Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		Last name on health card:		Health Insurance Number	Version Code
Accommodation preferred: <input type="checkbox"/> Ward <input type="checkbox"/> Semi-private <input type="checkbox"/> Private				Insurance attached: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Primary Contact Information					
Name		Relationship		Substitute Decision Maker (SDM) <input type="checkbox"/> Yes <input type="checkbox"/> No	
SDM Contact/Contacts: <input type="checkbox"/> SDM jointly <input type="checkbox"/> SDM severely		SDM Contact/Contacts: <input type="checkbox"/> SDM jointly <input type="checkbox"/> SDM severely			
Address same as patient <input type="checkbox"/> Yes <input type="checkbox"/> No <i>if different include below:</i>		City & Prov.		Postal Code	
Power of Attorney for Personal Care? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)		Power of Attorney for Property Decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)			
Address		City	Prov.	Postal Code	
Telephone of primary SDM contact (home) Telephone (cell)		Telephone (work)			Ext.
Alternate Contact Information					
Name		Relationship		Substitute Decision Maker (SDM) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Power of Attorney for Personal Care? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)		Power of Attorney for Property Decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach document)			
Address		City	Prov.	Postal Code	
Telephone (home) Telephone (cell)		Telephone (work)			Ext.

Palliative Care Hospice and In-Patient Referral

Patient/SDM (if mentally incapable) requesting resuscitation or other life sustaining interventions? ☐ Yes ☐ No
(Please note, resuscitation is not a treatment option for EOL care)

Current Isolation Issues: ☐ Yes ☐ No

Positive for (C Diff is exclusion criteria for all hospice sites):
☐ MRSA ☐ VRE ☐ C Diff. ☐ Other

Hep C status:

COVID Status

Positive for Covid 19 : ☐ Yes ☐ No ☐ Pending Date of positive swab:

Date of negative or pending swab:

If positive, have you had any further swabs? ☐ Yes ☐ No Result: ☐ Positive ☐ Negative ☐ Pending
If yes, list date: _____

Outstanding Medical Investigations:

FAX COMPLETED FORM TO LHIN 519-742-0635

(Patient Name/Label)

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Admission Location Requested:	Please select the patient's site choice. For multiple choices, please rank site choice from 1 to 7. 1= First choice, 2= Second choice, 3= Third choice, 4 = Fourth choice, 5 = Fifth choice, 6 = Sixth choice, 7 = Seventh choice							
	Lisaard House - Cambridge	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	Innisfree House - Kitchener	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	Hospice Wellington - Guelph	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	Hospice Waterloo Region	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	GRH Freeport - Kitchener	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	SJHCG - Guelph	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
	GMCH- Fergus	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 6 th	<input type="checkbox"/> 7 th
Mandatory Field- Priority Ranking- Check one of the following: <input type="checkbox"/> Priority 1- Crisis <input type="checkbox"/> Priority 2- Non-Crisis <input type="checkbox"/> Priority 3- Back-up Plan (End of Life- Hospice only)								
Referral Source :								
<input type="checkbox"/> Hospital In-patient unit <input type="checkbox"/> Hospital – ED <input type="checkbox"/> Community								
Facility/Community Agency:						Location/Unit:		
Status Update Contact Person:								
Phone:			ext:		Pager:		Fax:	
Bed Offer Contact Person:								
Phone:			ext:		Pager:		Fax:	
Primary Palliative Diagnosis:						Date of Diagnosis:		
Metastatic Spread (if malignant)								
Relevant Co-morbidities								
Reason for Referral						<input type="checkbox"/> Pain & Symptom Management: Time-limited for uncontrolled symptoms in person with life threatening illness. When stabilized, patients are assessed for discharge. ESAS (attach if available): _____ What are the symptoms that require management? <input type="checkbox"/> End of Life Care/Hospice (EOL): Range of palliative care to meet the needs of patients at end of life. <input type="checkbox"/> EOL care needs exceed capacity of care at home <input type="checkbox"/> Caregiver/s and/or informal supports inability to cope at home <input type="checkbox"/> Individual does not wish to die at home <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Back Up Plan (Hospice sites only)		

Prognosis Mandatory Field	<p>Current PPS Score: _____ Date of last assessment _____</p> <p>Oral intake has <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No change</p> <p>Prognosis: <input type="checkbox"/> < 1 month <input type="checkbox"/> < 3 month <input type="checkbox"/> < 6 months as determined by: Palliative Health Care Practitioner (please provide clinician name below, that confirmed palliative prognosis): _____</p> <p>Does the patient have informed consent about palliative approach to care and the care provision in Residential Hospice/CCC bed unit <input type="checkbox"/> Yes <input type="checkbox"/> Informed patient of palliative approach to care & provision of care</p> <p>Individual aware of: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis <input type="checkbox"/> Does not wish to know Family are aware of: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis <input type="checkbox"/> Does not wish to know</p> <p>If family is not aware, individual has given consent to inform family of:</p> <p>Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No Prognosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Primary Interventions and Treatments Mandatory Field	<p>Please outline previous interventions or treatments for symptoms related to the primary diagnosis below (For residents in retirement homes or other congregate settings please provide documentation that supports resident diagnosis and prognosis):</p>
Care Issues (please check all that apply)	<p><input type="checkbox"/> EOL Care/Death Management <input type="checkbox"/> Pain & Symptom Management Beds <input type="checkbox"/> Disease Management <input type="checkbox"/> Social Work <input type="checkbox"/> Spiritual Care <input type="checkbox"/> Psychological <input type="checkbox"/> Loss & Grief (legacy work, anticipatory grief work) <input type="checkbox"/> Encouraged Advance Care Planning Conversations between patient and Substitute Decision Maker <input type="checkbox"/> Reviewed role of Substitute Decision Maker with the patient's SDM</p> <p>Is there a known patient goal to access Medical Assistance in Dying? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, requires further conversations with receiving sites, please contact clinical resource nurse at receiving site.</i></p>

Discharge Potential (only applicable for Pain & Symptom management)	Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met? Yes <input type="checkbox"/> No <input type="checkbox"/> What are the barriers for discharge to the previous living arrangements? What are the alternate options? <input type="checkbox"/> Patient/SDM are aware that if the symptoms stabilize, discharge planning will proceed. Please provide specific details of the patient/SDM plan of care should the patient stabilize and discharge plans required :	
Special care considerations (please check all that apply and elaborate) <i>*Early consultation required for patients with oxygen greater than 6L/min to support safe transportation and oxygen delivery in the Hospice setting</i>	<input type="checkbox"/> Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No known allergies (NKA) Describe:	<input type="checkbox"/> Central line: <input type="checkbox"/> IV: <input type="checkbox"/> Pain pump:
	<input type="checkbox"/> Diet: <input type="checkbox"/> Tube feed:	<input type="checkbox"/> Wound: <input type="checkbox"/> Drains:
	<input type="checkbox"/> Hydration <input type="checkbox"/> Transfusion	<input type="checkbox"/> Dialysis Run/day/time: _____ <input type="checkbox"/> Peritoneal dialysis <input type="checkbox"/> Hemodialysis Dialysis Discontinuation Date: _____ Review by renal team required: _____
	<input type="checkbox"/> Oxygen: How many L/min _____ Type of oxygen delivery system: <input type="checkbox"/> N/P <input type="checkbox"/> Face Mask <input type="checkbox"/> CIPAP <input type="checkbox"/> BIPAP <input type="checkbox"/> Nebulizer <input type="checkbox"/> Tracheostomy: if ✓ please contact receiving site to review	<input type="checkbox"/> Ongoing treatment for symptom relief (Chemo, radiation, Dialysis):
	<input type="checkbox"/> Cognition/Dementia Issues Please identify risk behaviours:	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal defibrillator Has it been deactivated <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Additional equipment required?	
RELEVANT ATTACHMENTS (please provide the following if not available to the receiving organization electronically) Please note that Hospice may not have access to clinical connect please provide the following		
<div> <input type="checkbox"/> Most recent/relevant Patient History/Consultation reports <input type="checkbox"/> MAR/Home Medication List </div> <div> <input type="checkbox"/> Letter of Understanding <input type="checkbox"/> Most recent Physician, Nursing, Allied Health Progress Notes </div>		

Palliative Care Hospice & In-Patient Letter of Understanding

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Grand River hospital- Freeport, Kitchener <input type="checkbox"/> Groves Memorial Hospital- Fergus <input type="checkbox"/> St. Joseph's Health Centre- Guelph <input type="checkbox"/> Hospice Wellington- Guelph <input type="checkbox"/> Lisaard House- Cambridge <input type="checkbox"/> Innisfree House- Kitchener <input type="checkbox"/> Hospice Waterloo Region

I understand this means:

1. I have discussed the requested program with the referral source contact below

_____. Referral Source contact # _____
 (Print Name of Referral Source)

2. I fully understand what the program is and what is expected of me as a patient participating in the program.

I authorize the release of my personal and medical information to the requested program.

 Signature of Patient/Substitute Decision Maker

 Date:

☐ Consent obtained verbally

 Signature of Witness

 Date

 Name of Individual Obtaining Consent

 Date:

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How is Crisis defined?

A patient is considered to be "In Crisis" if:

1. Patient and/or caregiver safety is at risk and/or there is a risk that a significant health event and/or challenging end-of-life symptoms cannot be managed in their current setting
2. Patient at risk of requiring ED or acute care admission
3. Community resources have been exhausted and family/ caregivers are unable to cope with the patient's care needs
4. There is a risk that the services required to meet the patient's end-of-life care plan goals may not be available in their current setting
5. Patient at risk of not accessing their preferred place of death (considering recent trajectory of the PPS score).