Ontario Health atHome

NSM Common Palliative Referral

TO ALL PALLIATIVE CARE PROVIDERS

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

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.

Please complete sections that pertain to your referral (not all sections require completion)

Patient Identification:

Name (surname, first name): _____

HCN: _____ Version: _____

Client #: BRN: Date of Birth (yyyy/mm/dd):

Ontario Health atHome Care Coordinator (if known):

(Referring) Physician: **Phone:** **Fax:**

Date of Referral:

Application Checklist (include if available/applicable: Recent Consultation Notes, Communication to the individual's family physician of referral for palliative care services, Copy of completed Do Not Resuscitate Confirmation Form)

☐ Medical Orders attached e.g. wound care, central line care, drainage care (pleural/ascitic fluid management)

Type(s) of Services Requested

☐ **Community Palliative Care Provider Services**

Referral is for:

- ☐ Transfer of care to palliative MD/NP
- ☐ Shared care for palliative approach to care (patient stays rostered with primary care MD/NP where applicable)
- ☐ Couchiching Only - Transfer to family physician/ NP who accepts palliative patients

☐ **Community Hospice Services**

Specifics:

☐ **Medical Assistance in Dying (MAiD)**

- ☐ 1st Assessment
- ☐ 2nd Assessment
- ☐ Provision

☐ **Home and Community Care Support Services NSM**

- ☐ Hospice Palliative Care Nurse Practitioner
- ☐ Nursing (Complete medical referral form if orders required – link below)
- ☐ Occupational Therapy
- ☐ Personal Support Services
- ☐ Wound Care
- ☐ Pain symptom management (Ontario Health atHome CC determines internal/external)
- ☐ Physiotherapy
- ☐ Dietician
- ☐ Social Work
- ☐ Respiratory Therapy
- ☐ Speech Therapy

☐ **Pain and Symptom Management Joint Visit Request with NSM HPCN Palliative Pain and Symptom Management Consultant (PPSMC)**

☐ OHaH NSM requesting ☐ Service provider organization requesting ☐ Physician requesting/attending ☐ Other requesting

Requestor name and contact information:

☐ **Hospice Residence**

Fax to HCCSS NSM at

- 705-797-2401 (1-866-619-5669)

Select Hospice choice(s) below:

- ☐ Hospice Georgian Triangle (Campbell House)
- ☐ Hospice Huntsville (Algonquin Grace)
- ☐ Hospice Huronia (Tomkins House)
- ☐ Hospice Muskoka (Andy's House)
- ☐ Hospice Orillia (Mariposa House)
- ☐ Hospice Respite (Georgian Triangle)
- ☐ Hospice Simcoe
- ☐ Other (specify):

For Ontario Health atHome Care Coordinator Only

Where 911 is called and **an alternate destination is a option**, please select which hospices patient has consented to attend for treatment of symptoms

- ☐ Hospice Georgian Triangle
- ☐ Hospice Huntsville
- ☐ Hospice Huronia
- ☐ Hospice Muskoka
- ☐ Hospice Orillia
- ☐ Hospice Respite
- ☐ Hospice Simcoe
- ☐ Other (specify):

FOR HOSPICE USE ONLY:

EDITH form in home ☐ yes ☐ no

SRK in home ☐ yes ☐ no

Urgency of Response: ☐ 1 to 2 days ☐ 1 to 2 weeks ☐ Future

NOTE: if urgent response is required within 1-2 days, a phone contact must be made from the service requested

Name:
HCN: Ver:
BRN:
Care Coordinator:

PATIENT INFORMATION

Home Address: _____
(Street No., Street Name, Building) *(Apt/Suite #)* *(Entry Code)*

City: **Postal Code:**

☐ Lives alone ☐ Young children in the home ☐ Smoking in the home ☐ Pet(s) in the home *(specify)*:

Home Phone Number: **Alternate Number:**

Gender: ☐ Male ☐ Female ☐ Other:

Faith/Religion:

Primary Language(s):

Translator Name: _____
Phone:

Patient Identifies as: ☐ Francophone ☐ First Nation, Inuit, Metis, ☐ Other:

Current Location: ☐ Home ☐ Residential Hospice ☐ Other *(specify address)*:

☐ **Hospital:** _____ **Estimated Date of Discharge:**
(Name of hospital) *(yyyy-mm-dd)*

Primary Palliative Diagnosis: **Date of Diagnosis:**
(yyyy-mm-dd)

If Cancer Diagnosis – Metastatic Spread/Ongoing Treatment: ☐ yes ☐ no **Describe:**

Individual Aware of: **Diagnosis:** ☐ yes ☐ no **Prognosis:** ☐ yes ☐ no **Does Not Wish to Know:** ☐ yes ☐ no
Family 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

Anticipated Prognosis: ☐ Less than 1 month ☐ Less than 3 months ☐ Less than 6 months ☐ Less than 12 months ☐ Uncertain

Determined By *(Name and Phone Number)*:

Functional Status: Palliative Performance Scale (PPS) – Refer FAQs for more details
PPS: ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Resuscitation Status: Do Not Resuscitate ☐ yes ☐ no ☐ unknown ☐ Form sent home with patient
Discussed with: Individual: ☐ yes ☐ no Family: ☐ yes ☐ no

Family/Informal Caregivers: Provide Power of Attorney for Personal Care *(if known)*

Name	Relationship	Home Phone	Business/Cell Phone

Please List All Providers and Services Currently Involved *(if known)*

	Name	Phone	Fax
Family Physician			
Community Nursing			
Hospice			
Other			

Co-Morbidities: ☐ **Check here if documentation is attached**

Year *(yyyy-mm-dd)*	Diagnosis	Year *(yyyy-mm-dd)*	Diagnosis

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(Specify Precaution)*:

Required information: As available, reports must be within the last 2 weeks, at time of referral, and include treatment provided. If referring from acute care facility, this information must be included.

Allergies: ☐ yes ☐ no ☐ unknown If yes *(please specify)*:

Pharmacy (Name and Phone) – if known:

Name:
HCN: Ver:
BRN:
Care Coordinator:

Current Medications: ☐ Medication List Attached

Drug	Dose	Route	Interval	Drug	Dose	Route	Interval

Details of Social Situation, Including Any Needs/Concerns of Family:

Special Care Needs: *(Please Check All that Apply)*

☐ Transfusion ☐ Hydration ☐ Subcutaneous ☐ Intravenous ☐ Infusion Pump(s) ☐ Total Parental Nutrition
☐ Dialysis ☐ Enteral Feeds ☐ Tracheostomy ☐ PortaCath ☐ Central Line(s) ☐ P.I.C.C. Line(s)
☐ Oxygen – Rate: _____ ☐ Thoracentesis ☐ Paracentesis ☐ Drains/Catheter *(Specify)*: _____
☐ Wound Care *(Specify)*: _____
☐ Therapeutic Surface *(Specify)* : _____
☐ Other Needs:

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 – See FAQs for Details)

Pain:	Tiredness:	Nausea:	Depression:	Drowsiness:	Appetite:
Well-Being:	Shortness of Breath:	Anxiety:	Other:		

Date ESAS Completed: _____ *(yyyy-mm-dd)*

Insurance Information:

Any Additional Information:

Form Completed by:	**Phone:**	**Fax:**
Professional Designation:		

Ontario Health atHome - Adult Medical Referral Form

Medication List

Patient Identification:

Name: _____
(*surname, first name*)

HCN: _____Version:_____

CTN: _____

BRN: _____

	Drug Name	Dose	Route	Freq.	Routine or PRN	If PRN: # of times taken in last 7 days
1.						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						

Name (print): _____ Signature: _____ Date:_____

Hospice Respite Bed Eligibility

Team:	**Patient Identification**:
☐ Barrie & Area ☐ Collingwood & Area ☐ Midland & Area ☐ Muskoka ☐ Orillia & Area ☐ Short Stay ☐ Support Team	Name (surname, first name): _____ HCN: _____Version:_____ Client #: _____ BRN: _____ CC/Coordinator: _____

- ☐ Patient is in a state of progressive functional decline with a life threatening, progressive or terminal illness requiring a palliative approach.
- ☐ The person requires a period of time in which to stabilize an exacerbation of life-limiting illnesses that puts him/her at risk of visiting an ED or hospitals.
- ☐ The person requires 24/7 support and has temporarily unmet needs.
- ☐ Stay is days to a maximum of 2 weeks.
- ☐ Patient and caregiver must have an expressed plan to return home AND HAVE A HOME TO RETURN TO.
- ☐ Patient/SDM are aware that they will be asked to sign a Hospice Respite admission agreement upon admission.
- ☐ Priority will be given to community patients over hospitalized ones.
- ☐ Prognosis is less than 6 months, is eligible for end of life Ontario Health atHome designation.
- ☐ A Do Not Resuscitate (DNR) order is in place.
- ☐ Patient's medical care needs can be met at hospice facility using a palliative approach.
- ☐ Patient exhibits **NO** evidence of violence or aggression.
- ☐ Patient understands that diagnostic testing is not offered unless for Pain and Symptom Management and comfort care.
- ☐ Patient has a valid Ontario Health Card if referred by HCCSS.
- ☐ The community MRP will be established prior to admission and provide standing orders for the stay.
- ☐ Any transportation needs and requirements are managed and arranged by the patient or family.

Care Coordinator Signature: Date: