HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Sud-Ouest

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Palliative Care – Community Services Assessment Request

Important Instructions

- **Referrals without sufficient information will be returned to the referral source with further direction.**
- **Responsibility for medical care will remain with the primary care provider unless otherwise notified.**
- **Hospital referrers, please contact the HCCSS South West hospital care coordinator prior to discharge for an assessment to inform service planning.**

Please complete the referral form in its entirety and fax completed form to Home and Community Care Support Services South West (HCCSS South West) at **1-833-841-5369**

**** The referral will be triaged based on the information provided in this form ****

Attach relevant documents to support this referral (e.g. consult notes, current medication list, imaging results, etc.)

Patient Information

Surname	First Name	Date of Birth (DD-Month-YYYY)

Home Address	City	Postal Code

Health Card Number	Version Code	Phone Number

Does the patient prefer/need an alternate contact? If yes, indicate in the Alternate Contact Information section.
☐ No ☐ Yes

Assigned sex at birth
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Non-Binary ☐ Transgender Female ☐ Transgender Male ☐ Gender Variant/Non-conforming
☐ Prefer not to disclose ☐ Not Listed:

Alternate Contact Information

Surname	First Name

Relationship to Patient	Phone Number

Referral Urgency

Urgency of Referral

☐ 1-2 weeks (If care is required prior to this timeframe, please fax referral to 1-833-841-5369 and call 1-855-474-5754, 7 days a week, 0800-2000 hrs).

☐ 2+ weeks

Primary Care Provider (PCP) Details

Does the patient have a PCP?
☐ Yes ☐ No

Is the PCP aware of the referral and that the responsibility for medical care will remain with the PCP unless otherwise notified?
☐ Yes ☐ No (If no, PCP must be made aware at earliest opportunity)

Primary Care Provider Name	CPSO/CNO Registration (if applicable)

Daytime Phone Number	After-Hours Phone Number	Fax Number

City	Postal Code

Ontario

Surname	First Name	Health Card Number

Pertinent Medical Information

Primary Diagnosis	Date of Diagnosis (DD-Month-YYYY)

Anticipated Prognosis

☐ days to weeks ☐ less than 3 months ☐ 3-6 months ☐ 6 months to one year

Pain and Symptoms

☐ Palliative Pain Location:

☐ Shortness of Breath: ☐ at rest ☐ on exertion ☐ home oxygen

☐ Nausea

☐ Other:

Health History (Please attach relevant medical documents)

Reason for Referral

☐ HCCSS Care Coordinator to Assess Eligibility for Home and Community Care Services

☐ Palliative MD/NP Consultation/Involvement

Details on Requested Support

Attach relevant documents (e.g. current medication list, imaging results, consult notes)

Palliative Performance Scale (PPS): See attached table to complete PPS.

☐ PPS 50% or more (up and out of chair/bed for more than half day, completes most activities of daily living [ADLs] on their own)

☐ PPS 40% (mostly in bed, assistance required for ADLs)

☐ PPS 30% or less (bed bound, complete care for ADLs, reduced/minimal oral intake)

Goals of care conversation (resuscitation status, care location, preferred end-of-life location, understanding of illness and treatment options) completed with patient/SDM

☐ No ☐ Yes

If YES, please provide details:

Resuscitation Status (If **not** discussed, please leave blank)

☐ Full Code (Cardiopulmonary Resuscitation [CPR] and all life-saving measures, transfer to acute care; default if patient is undecided)

☐ Do Not Resuscitate (DNR) (Please attach signed DNR-C, if available)

End-of-Life Preference

☐ Home ☐ Hospice ☐ Hospital ☐ Undecided ☐ Not discussed

Surname	First Name	Health Card Number

Consent and Referrer Details

☐ I have informed the patient/substitute decision maker (SDM) of this referral to receive palliative services and that he/she/they consented. Referral will be returned if consent has not been obtained from patient/SDM.

Referrer Name and Designation	CPSO/CNO/College Registration	OHIP Billing Number

Phone Number	Fax Number

Office Address	

City	Postal Code

Referrer Signature	Date Signed (DD-Month-YYYY)

Reminder

Please complete the referral form in its entirety and fax completed form to Home and Community Care Support Services South West (HCCSS South West) at **1-833-841-5369**

**** The referral will be triaged based on the information in this form ****

Attach relevant documents to support this referral (e.g. current medication list, imaging results, consult notes)

The referral will be reviewed and services assessed by the HCCSS South West Care Coordinator for your patient.

Thank you for your submission.

Palliative Performance Scale (PPS version 2)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma +/- confusion
0%	Death	-	-	-	-