Ontario Health atHome

Hospice Referral Form

	☐	☐	☐	☐	☐	☐	☐
Hospice	Emmanuel House	Carpenter House	Hospice Niagara	McNally House	Bob Kemp	Stedman	Margaret's Place
Fax #	905-308-8116	905-631-7107	905-646-3860	905-309-6656	905-318-8411	519-751-7527	905-627-6577

Patient Information

BRN#

Patient Name _____ **HCN** _____ **VC** _____ **DOB** _____

Address _____ **City** _____ **Province** _____ **Postal Code** _____

Patient Phone # _____ **Current Location** _____

SDM _____ **Relationship** _____ **Phone** _____

Preferred Language _____ **Gender Identity** _____

Care Coordinator _____ **Phone** _____ **Ext.** _____

Service(s) Requested (please check all that apply)

☐ **Residence Bed** ☐ **Day Program** ☐ **Outreach Team** ☐ **Visiting Volunteer** ☐ **Bereavement** ☐ **Psychosocial Spiritual**

Primary Community Health Care Provider Information

Community MRP Name _____ **MRP aware of referral request?** ☐ **Yes** ☐ **No** ☐ **Unknown**

MRP Phone _____ **Backline or Cell** _____ **MRP Fax** _____

Primary Specialist _____ **Phone** _____ **Fax** _____

Medical Information

Primary Diagnosis _____ **Date of Onset** _____ **PPS** _____

Secondary Diagnoses / Comorbidities _____

Allergies _____

Symptoms Requiring Management (nausea, pain, etc.) _____

_____

Patient & Family's Goals & Expectations _____

Other Relevant Information _____ **DNR** ☐**Yes** ☐ **No**

History of: **MRSA** ☐**Yes** ☐**No** ☐**Unknown** **VRE** ☐**Yes** ☐**No** ☐**Unknown** **C-Diff** ☐**Yes** ☐**No** ☐**Unknown**

COVID Vaccination ☐ **Unimmunized** ☐ **Partially Immunized** ☐ **Fully Immunized** **Date of Last Dose:** _____

Attachments ☐**Medical Summary / Health History** ☐**Consult / Progress Notes** ☐**Other Notes** ☐**Pertinent Diagnostic Tests**
☐ **Current Medication List** ☐ **Pharmacy** _____

Referral Source

Referring Practitioner Name _____ **Position** _____

Organization _____ **Phone** _____ **Ext.** _____

Signature _____ **Date** _____

HOSPICE NIAGARA Helping you live well
McNally House
KEMP HOSPICE Compassionate Palliative Care
Stedman Community Hospice
Good Shepherd Faith in people.
Carpenter Hospice
MARGARET'S PLACE Hospice at St. Joseph's Villa

Version **21-004**
June 28, 2024

Print Clear

Patient Name_____ **BRN #** _____

Palliative Performance Status (PPS) Guide

(✓)	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	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	Full or Drowsy +/- Confusion
☐	0%	Death				

Hospice Services Available by Location

Hospice	Location	Phone Number	Residence Beds	Day Programs	Outreach Team	Visiting Volunteer	Psychosocial Spiritual Bereavement
Emmanuel House	Hamilton	905-308-8401	Yes	No	Yes	No	Yes
McNally House	Grimsby	905-309-4013	Yes	No	No	No	Yes
Hospice Niagara	St. Catharines	905-984-8766	Yes	Yes	Yes	Yes	Yes
Carpenter Hospice	Burlington	905-631-9994	Yes	Yes	Yes	No	Yes
Bob Kemp	Hamilton	905-387-2448	Yes	Yes	Yes	Yes	Yes
Stedman	Brantford	519-751-7096 ext. 2500	Yes	Yes	Yes	No	Yes
Margaret's Place	Hamilton	905-627-6577	Yes	Yes	Yes	No	Yes

Referral Eligibility for Hospice Residence Confirmed by

Care Coordinator_____ **Date**_____ **Phone #** _____