Ontario Health atHome

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

Palliative Care – Hospice Bed Referral

Incomplete referrals will be returned to the referral source with direction for completion

Referral Urgency

◯ Urgent (within 24 hours) ◯ Non-Urgent ◯ Pre-registration for future admission

Exceptions: St. Joseph's Hospice of London, Parkwood Institute, Barrie Family Hospice of Elgin

Patient Information

Surname		First Name
Home Address		
City		Postal Code
Health Card Number	Version Code	Date of Birth (YYYY-Month-DD)
Billing Reference Number (BRN)	Telephone Number	Email Address
Preferred Provincial Language ◯ English ◯ French	Assigned Sex at Birth ◯ Male ◯ Female	Gender Identity ☐ Prefer not to disclose

Patient's Current Location (e.g., home, hospital inclusive of floor and nursing station extension number, long-term care)

Form Instructions

Please fax the completed form to the appropriate region noted below:

London Middlesex	519-472-3257	Elgin	519-631-6968	Huron Perth	519-273-6454
		Oxford	519-539-6351	Grey Bruce	519-881-1425

For urgent admissions to Parkwood Palliative Care Unit (PCU), please fax to 519-685-4804 **and** to the appropriate Ontario Health atHome number noted above.

Hospice Beds

Use numerical values to rank choices, e.g., 1, 2, 3

Grey-Bruce County	**London and Middlesex County**
Grey Bruce Hospice Inc. (Chapman House) (Owen Sound)	Parkwood Institute - Palliative Care Unit (PCU) (London)
Huron Shores Hospice (Tiverton)	St. Joseph's Hospice of London
Huron Perth Counties	**Oxford County**
Huron Hospice Bender House (Clinton)	Sakura House Hospice (Woodstock)
Jessica's House Hospice (Exeter)	**Elgin County**
Rotary Hospice Stratford Perth (Stratford)	Barrie Family Hospice of Elgin (St. Thomas)

Surname	First Name	Health Card Number

Alternate Contact Information

◯ Patient prefers/requires an alternate contact ◯ Not required

Surname	First Name
Relationship to Patient	Direct Telephone Number

Substitute Decision Maker or Power of Attorney for Care

◯ Substitute decision maker (SDM) based on hierarchy

◯ Power of Attorney (POA) for Personal Care

SDM/POA Name	Relationship to Patient	Direct Telephone Number
SDM/POA Name	Relationship to Patient	Direct Telephone Number
SDM/POA Name	Relationship to Patient	Direct Telephone Number

Primary Care Provider Information

Primary Care Provider Name	CPSO/CNO/Registration Number
Direct Telephone Number	Fax Number
Primary Care Provider is aware of this referral? ◯ Yes ◯ No	Most Responsible Provider in Hospice ◯ Primary care provider ◯ Hospice physician

Pharmacy Information

Pharmacy Name	Direct Telephone Number	Fax Number
Additional coverage available ◯ Yes (If yes, provide carrier name and policy number) ◯ No	Carrier Name and Policy Number	

Clinical Information

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

Additional Diagnose(s)

Allergies ☐ No known allergies

Height	Weight (mandatory) ◯ lb ◯ kg	Palliative Performance Scale (PPS)	Date PPS Assessed (YYYY-Month-DD)

Anticipated Prognosis (per medical physician or nurse practitioner)

◯ Days ◯ Weeks ◯ Less than three months ◯ Greater than three months (pre-registration only)

Prognosis Information Obtained From

Edmonton Symptom Assessment System (ESAS) score at the time of referral (Rate: 0 = symptom is absent to 10 = worst possible severity

Pain	Tiredness	Drowsiness	Nausea	Appetite	Breathlessness	Depression	Anxiety	Wellbeing

Surname	First Name	Health Card Number

Current Care and Equipment Needs

- ☐ Central Line(s) Type:
- ☐ Intravenous medication(s)
- ☐ Tranfusions
- ☐ Drain(s) Type:
- ☐ Foley catheter Size:
- ☐ Ileal conduit
- ☐ Suprapubic catheter
- ☐ Ostomy
- ☐ Tracheostomy
- ☐ Wound care
- ☐ Pacemaker
- ☐ Implantable Cardioverter Defibrillator (ICD)
  Deactivated: ◯ Yes ◯ No
- ☐ Peripherally Inserted Central Catheter (PICC)
- ☐ Symptom Response Kit (SRK)
- ☐ Subcutaneous medication(s) started
- ☐ Spinal analgesia
- ☐ Hydration
- ☐ Paracentesis
- ☐ Thoracentesis
- ☐ Dialysis: ◯ Hemodialysis ◯ Peritoneal dialysis
- ☐ Enteral Feeds: ◯ Bolus ◯ Continuous
- ☐ Ventilation: Vendor
- ☐ Continuous Positive Airway Pressure
- ☐ Invasive

☐ Oxygen: ☐ Mask ☐ Nasal Prongs High Flow: Rate: L/min

Ventilation and Oxygen Equipment: ◯ Rent ◯ Own

Ongoing Treatments

◯ No treatment ◯ Radiation ◯ Chemotherapy

Patients/caregivers are responsible for transportation to appointments

Antibiotic(s): ◯ Oral ◯ Intravenous (IV)

Purpose of Treatment

- ☐ Life Extending
- ☐ Comfort Measures

Contact Precautions

- ☐ Vancomycin-resistant Enterococcus (VRE)
- ☐ Extended-spectrum beta-lactamase bacteria (ESBL)
- ☐ Methicillin-resistant Staphylococcus Aureus (MRSA)
- ☐ Clostridioides difficile:
- ☐ COVID-19:

Date (YYYY-Month-DD) of Confirmation

Transfers, Mobility Aids and Adaptive Equipment

Therapeutic Surface(s)

Other Needs (e.g., bariatric equipment)

Additional Information (e.g., smoker, substance abuse, relevant social or behavioural information)

Surname	First Name	Health Card Number

Patient Goals

◯ Care and Comfort

◯ Other:

Resuscitation Status

◯ Do not Resuscitate Confirmation (DNRc)

◯ Full Code

After-Death Information

Funeral Home/Crematorium Name and Who spoke to	Funeral Home / Crematorium Telephone Number
Funeral Home / Crematorium Email Address	Funeral Home / Crematorium Fax Number

Required Documents

(*) Mandatory documents; all others are as applicable.

- ☐ Last RAI document*
- ☐ Applicable CHRIS notes*
- ☐ Do Not Resuscitate Confirmation (DNRc)*
- ☐ Recent Consult Notes*
- ☐ Current Medication List*
- ☐ Hospital Admission History
- ☐ Behavioural Assessment
- ☐ MAiD Documents (e.g., Form A and C)
- ☐ Wound Care Assessment

Note: patients are required to bring medications they are currently taking with them to hospice, if coming from home.

Declaration

Referrer Name	CPSO/CNO/Registration Number
Role and Designation	Organization
Referrer Telephone Number	Referrer Fax Number
Referrer Signature	Signature Date (YYYY-Month-DD)