**HOME AND COMMUNITY CARE SUPPORT SERVICES**

**North Simcoe Muskoka** Page 1 of 3

**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):  |       |
| **HCCSS 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 car 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 (HCCSS 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)**[ ]  HCCSS NSM requesting [ ]  Service provider organization requesting [ ]  Physician requesting/attending [ ]  Other requestingRequestor 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 HCCSS 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 [ ]  noSRK 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** |
|  |
| **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 | **Faith/Religion:** |       |
|  | [ ]  Female |  |  |
|  | [ ]  Other:  |       |
| **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:       |
| **Current Medications:** [ ]  Medication List Attached |
| **Drug** | **Dose** | **Route** | **Interval** | **Drug** | **Dose** | **Route** | **Interval** |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
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|       |       |       |       |       |       |       |       |
| **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:**  |       | **Insurance Information:**  |       |
|  | *(yyyy-mm-dd)* |  |
| **Any Additional Information:**      |
| **Form Completed by:**       | **Phone:**       | **Fax:**       |
| **Professional Designation:**       |

[Home and Community Care Support Services NSM - Adult Medical Referral Form](https://healthcareathome.ca/document/medical-referral-form-adult/)