Palliative Care Common Referral Form Toronto Central Palliative Care Network		
TO ALL PALLIATIVE CARE PROVIDERS		
(For the purpose of this Form, an individual refers to a patient or client	t)	
Your submission of this form will be taken to explicitly mean that you information contained to the agencies and services to whom you are Release of Information Form, if applicable.		
Please complete this form as thoroughly as possible and PRINT cleadecide which practitioner(s) is most appropriate to complete each se		itution should
Individual's Last Name:	First Name:	
Goals of Care/ Reason for Referral:		
Application Checklist (include if available):		
Care protocols attached e.g. wound care, central line care, drain	nage care (pleural/ascitic fluid managem	ent)
☐ Communication to the individual's family physician of referral for	r palliative care services	
☐ Copy of completed Do Not Resuscitate Confirmation Form		
☐ Diagnostic imaging (X-ray, Ultrasound, CT scan, MRI) ☐	Recent chest x-ray	
☐ Infection control management (e.g. MRSA/VRE/C-DIFF, etc.) A	s available, reports must be current w	ithin the last
2 weeks, at time of referral, and include treatment provided. If remust be included.		
☐ Recent consultation notes ☐ Recent laboratory results	☐ Pathology reports	
Note: Referral Source must be responsible to send referral to		ove: If
urgency request is within 1-2 days, a phone contact must be ma		ove, ii
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		Pages
Type(s) of services requested	Urgency of response	Required
Community Care Access Centre (complete CCAC Medical Referral	☐ 1-2 days ☐ 1 - 2 weeks	Page 1-4
Form):	I I-2 days I I-2 weeks	Page 1-4
Community Palliative Care Physician		D
(Specify Palliative Physician Team):	☐ 1-2 days ☐ 1 - 2 weeks	Page 1-3
Referral is for: Consultative care Primary care		
☐ Hospice Program: ☐ Home Visiting ☐ Day Program	☐ 1-2 days ☐ 1 - 2 weeks ☐ Future	Page 1-4
Residential Hospice (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐Future	
Inpatient Palliative Care Unit (List all units referred):	☐ 1-2 days ☐ 1 - 2 weeks ☐ Future	Page 1-4
		. ugo 1 4
Other (specify):	☐ 1-2 days ☐ 1 - 2 weeks ☐ Future	

Please send directly to your desired hospice palliative care provider(s). Do not send to the Toronto Central Palliative Care Network.

☐ 1-2 days ☐ 1 - 2 weeks ☐Future

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¹ The Palliative Care Common Referral Form was originated from TIPCU (2004). This Form has been adapted from the Toronto Central Palliative Care Network Common Referral Form. Further uses of this Form are permitted, provided the original is unaltered.

Last Modified November 2010

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Palliative Care Common	Referral Form Toronto Cent	tral Palliative Care Network		
Home Address:		Apt:	Entry Code:	Postal Code:
Lives Alone	Young Children in the Home	☐ Smoking in the Home	· · · · · · · · · · · · · · · · · · ·	
Home phone numbe	r:	Alter	nate number:	
Date of birth: (DD/MM/	YY)	Geno	ler: Faith/Re	eligion:
Health card number:		Version code:		
Primary language(s):	: 	Transl	ator: (name/phone #):	
Current location:] Home ☐ Residential hosp	pice Other (specify addr	ess):	
] Hospital	Anticipated ho	spital discharge date:	
Primary palliative dia	ngnosis:	<u></u>	Da	te of Diagnosis
Other relevant diagn	osis/symptoms:			
If cancer diagnosis:	metastatic spread:	s No Describe:		
If cancer diagnosis:	ongoing treatment: 🗌 Ye	s No Describe:		
Individual aware of:	Diagnosis: ☐ Yes ☐ No	Prognosis: Yes No	Does not wish to	know: 🗌 Yes 🔲 No
Family are aware of:	Diagnosis: Yes No	Prognosis: Yes No	Does not wish to	know: Yes No
If family is not aware, in	dividual has given consent to i	inform Family of: Diagnosis	s ☐ Yes ☐ No Proç	gnosis 🗌 Yes 🗌 No
Anticipated prognos Determined by (name and		3 months	hs	ns Uncertain
Functional status:	Palliative Performance Scale (PP:	S): refer FAQs for more details	□ 70% □ 80%	
	: Do Not Resuscitate ☐ Yes ual ☐ Yes ☐ No Family ☐			
Family/Informal Care	egivers: Provide Power Of	Attorney for Personal Ca	re if known:	
Name		Relationship	Home Phone	Business/Cell Phone
Please list all Provid	ers and Services currentl	y involved: (if Known)	Additional list at	tached
Name		Phone		Fax
Family Physician:				
CCAC				
Community Nursing				
Hospice				
Other				

Individual's First & Last Name:

Palliative Car	e Common Referra	l Form To	oronto Ce	ntral Palli	ative Care N	<u>etwork</u>	Individual's Fi	rst & Last	t Name:
Co-Morbidit	ties: 🗌 C	heck here	if docum	nentation	is attached				
Year	Diagnosis				Year	Diagnos	is		
Infection Co	ontrol: MRSA	VRE (+)	□ C	-DIFF (+)	☐ Othe	r (specify pre	ecaution):		
Allergies:	☐ Yes ☐ No	☐ Unkr	nown	☐ If Y	es (please	specify):			
Pharmacy (name and number)	If Known:							
Current me	dications: 🗌 me	dication I	ist attach	ed					
(Include comp	lementary alternati	ve medica	tions and	over-the-c	counter med	ications)			
Drug		Dose	Route	Interval	Drug		Dose	Route	Interval
							·		
Details of s	ocial situation, i	ncluding	any nee	ds/conc	erns of the	e family:			

Palliative Care Common Referral Form | Toronto Central Palliative Care Network Special care needs: (please check all that apply) ☐ Transfusion ☐ Hydration: ☐ SC or ☐ IV ☐ Total Parental Nutrition ☐ Enteral feeds ☐ Infusion pump(s) ☐ Dialysis Central line(s) P.I.C.C. line(s) ☐ PortaCath ☐ Tracheostomy ☐ Drains/Catheter (specify): Oxygen: rate: ☐ Thoracentesis Paracentesis (specify): ☐ Wound care ☐ 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 Other: Date ESAS completed: Insurance Information: Has expressed willingness to pay for private services: ☐ Yes □ No ☐ Not Known For inpatient palliative care units: ☐ Private accommodation requested Any additional information: **Individual Completing Form:** Fax: (Referring) Physician: Fax: Date of Referral: (DD/MM/YY)

Individual's First & Last Name: