



Palliative Care Hospice & In-Patient Referral

Date of Application:		Date of Admission:	
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Personal Information

Last Name		First Name		
Date of Birth		Age		Male Female
Address		Apt#	City	Prov. Postal Code
Home Telephone		Present Location (home, hospital, LTC, ED)		
Family Physician	Phone Fax	Most Responsible Physician	Phone Fax	

Health Insurance Information

Is patient covered under Ontario Health Insurance Plan? No Yes Last name on health card	Health Insurance Number	Version Code
Accommodation preferred Ward Semi-private Private	Insurance attached No Yes	

Emergency Contact Information

Next of kin/primary contact		Relationship		
Address		City	Prov.	Postal Code
Telephone (home)		Telephone (work)		Ext.
Power of Attorney (Please attach information)	Personal Care Name: Contact #	Financial Name: Contact #		

Advanced Care Directives in place (Please attach information)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Please note, resuscitation is not a treatment option for EOL care)
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Exclusion Criteria

- Those exhibiting violent or exit-seeking behaviors with tendency to harm self, others or property
- The patient is receiving curative disease modifying treatment
- Test positive (+) for C. Difficile (Hospice Wellington & Lisaard House only)

<input type="checkbox"/> Current Isolation Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No Positive for: <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C Diff. <input type="checkbox"/> Other	<input type="checkbox"/> Outstanding Medical Investigations: <hr/> <hr/>
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(Patient Name/Label)

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Discharge Potential	Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met Yes <input type="checkbox"/> No <input type="checkbox"/> What are the barriers for discharge? _____
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Care Issues (please check all that apply)	<input type="checkbox"/> Pain & Symptom Control <input type="checkbox"/> EOL Care/Death Management <input type="checkbox"/> Loss & Grief (legacy work, anticipatory grief work) <input type="checkbox"/> Disease management <input type="checkbox"/> Spiritual Care <input type="checkbox"/> Social Work <input type="checkbox"/> Psychological
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Special care considerations (please check all that apply and elaborate)	<input type="checkbox"/> Allergies:	<input type="checkbox"/> Central line: <input type="checkbox"/> IV: <input type="checkbox"/> Pain pump:
	<input type="checkbox"/> Diet:	<input type="checkbox"/> Wound:
	<input type="checkbox"/> Tube feed:	<input type="checkbox"/> Drains:
	<input type="checkbox"/> Hydration <input type="checkbox"/> Transfusion	<input type="checkbox"/> Dialysis Run/day/time: _____ <input type="checkbox"/> PD <input type="checkbox"/> Hemodialysis Review by renal team required. Note: Dialysis is not a treatment option for EOL care.
	<input type="checkbox"/> Oxygen: <input type="checkbox"/> Tracheotomy:	<input type="checkbox"/> Ongoing treatment for symptom relief (Chemo, radiation):
	<input type="checkbox"/> Cognition/Dementia Issues _____ _____	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal defibrillator Has it been deactivated <input type="checkbox"/> yes <input type="checkbox"/> no

RELEVANT ATTACHMENTS (please provide the following if not available to the receiving organization electronically)

<input type="checkbox"/> Most recent/relevant Patient History / Consultation reports	<input type="checkbox"/> MAR / Home Medication List
<input type="checkbox"/> Copy of Consent Form	<input type="checkbox"/> Most recent Physician, Nursing, Allied Health Progress Notes

FAX COMPLETED FORM TO:

Freeport: 519-749-4326

GMCH: 519- 843-7206

SJHCG: 519-767- 4151 Lisaard: 519-650-8058

Hospice Wellington Residence: 519-822-2660

CONSENT

Palliative Care Hospice & In-Patient Referral

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Grand River Hospital – Freeport, Kitchener <input type="checkbox"/> Groves Memorial Community Hospital – Fergus <input type="checkbox"/> Hospice Wellington - Guelph <input type="checkbox"/> Lisaard House - Cambridge <input type="checkbox"/> St. Joseph’s Health Centre - Guelph

I understand this means:

1. I have discussed the requested program with

_____.
(Print Name of Referral Source)

2. I fully understand what the program is and what is expected of me as a patient participating in the program.

I authorize the release of my personal and medical information to the requested program.

Name of Power of Attorney/Substitute Decision Maker (if applicable):

Signature of Patient/Power of Attorney/Substitute Decision Maker

Date

Signature of Witness

Date

Name of Individual Obtaining Consent

Date