Palliative Care Hospice and In-Patient Referral

Fill Patient Data

Date of Application:	Date of Admission:	BRN:

Personal Information

Last Name:		First Name:		
Date of Birth:	Age:	Sex: ☐ Male ☐ Female ☐ Intersex		
Gender: ☐ Prefer not to disclose ☐ I prefer to identify as: _____				
Pronoun patient identifies with (e.g.: he, she, they, ze): _____				
Address	Unit #	City	Prov.	Postal Code
Home Telephone	Present Location (home, hospital, LTC, ED)			
Family Physician/Primary Care Practitioner		Phone		Fax
Most Responsible Physician		Phone		Fax
Nurse Practitioner		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	

Primary Contact Information

Name	Relationship	Substitute Decision Maker (SDM) ☐ Yes ☐ No	
SDM Contact/Contacts: ☐ SDM jointly ☐ SDM severely	SDM Contact/Contacts: ☐ SDM jointly ☐ SDM severely		
Address same as patient ☐ Yes ☐ No *if different include below:*	City & Prov.	Postal Code	
Power of Attorney for Personal Care? ☐ Yes ☐ No (Please attach document)	Power of Attorney for Property Decisions? ☐ Yes ☐ No (Please attach document)		
Address	City	Prov.	Postal Code
Telephone of primary SDM contact (home) Telephone (cell)	Telephone (work)		Ext.

Alternate Contact Information

Name	Relationship	Substitute Decision Maker (SDM) ☐ Yes ☐ No	
Power of Attorney for Personal Care? ☐ Yes ☐ No (Please attach document)	Power of Attorney for Property Decisions? ☐ Yes ☐ No (Please attach document)		
Address	City	Prov.	Postal Code
Telephone (home) Telephone (cell)	Telephone (work)		Ext.

Palliative Care Hospice and In-Patient Referral		
Patient/SDM (if mentally incapable) requesting resuscitation or other life sustaining interventions? ☐ Yes ☐ No (Please note, resuscitation is not a treatment option for EOL care)		
Current Isolation Issues:	☐ Yes ☐ No	
Positive for (C Diff is exclusion criteria for all hospice sites):	☐ MRSA ☐ VRE ☐ C Diff. ☐ Other	
Hep C status:		
COVID Status		
Positive for Covid 19 :	☐ Yes ☐ No ☐ Pending	Date of positive swab:
Date of negative or pending swab:		
If positive, have you had any further swabs? ☐ Yes ☐ No If yes, list date: _____		Result: ☐ Positive ☐ Negative ☐ Pending
Outstanding Medical Investigations:		
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(Patient Name/Label)

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Admission Location Requested:	Please select the patient's site choice. For multiple choices, please rank site choice from 1 to 7. 1= First choice, 2= Second choice, 3= Third choice, 4 = Fourth choice, 5 = Fifth choice, 6 = Sixth choice, 7 = Seventh choice							
	Lisaard House - Cambridge	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	Innisfree House - Kitchener	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	Hospice Wellington - Guelph	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	Hospice Waterloo Region	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	GRH Freeport - Kitchener	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	SJHCG - Guelph	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th
	GMCH- Fergus	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐7th

Mandatory Field- Priority Ranking- Check one of the following:

☐ Priority 1- Crisis ☐ Priority 2- Non-Crisis ☐ Priority 3- Back-up Plan (End of Life- Hospice only)

Referral Source :

☐ Hospital In-patient unit ☐ Hospital – ED ☐ Community

Facility/Community Agency:		Location/Unit:
Status Update Contact Person:		
Phone: ext:	Pager:	Fax:
Bed Offer Contact Person:		
Phone: ext:	Pager:	Fax:

Primary Palliative Diagnosis:		Date of Diagnosis:
Metastatic Spread (if malignant)		
Relevant Co-morbidities		

Reason for Referral

☐ **Pain & Symptom Management:** Time-limited for uncontrolled symptoms in person with life threatening illness. When stabilized, patients are assessed for discharge. ESAS (attach if available): _____

What are the symptoms that require management?

☐ **End of Life Care/Hospice (EOL):** Range of palliative care to meet the needs of patients at end of life.
- ☐ EOL care needs exceed capacity of care at home
- ☐ Caregiver/s and/or informal supports inability to cope at home
- ☐ Individual does not wish to die at home
- ☐ Other (specify): _____

☐ **Back Up Plan** (Hospice sites only)

Prognosis Mandatory Field	Current PPS Score: _____ Date of last assessment _____ Oral intake has ☐ Increased ☐ Decreased ☐ No change Prognosis: ☐ < 1 month ☐ < 3 month ☐ < 6 months as determined by: Palliative Health Care Practitioner (please provide clinician name below, that confirmed palliative prognosis):_____ Does the patient have informed consent about palliative approach to care and the care provision in Residential Hospice/CCC bed unit ☐ Yes ☐ Informed patient of palliative approach to care & provision of care Individual aware of: ☐ Diagnosis ☐ Prognosis ☐ Does not wish to know Family are aware of: ☐ Diagnosis ☐ Prognosis ☐ Does not wish to know If family is not aware, individual has given consent to inform family of: Diagnosis ☐ Yes ☐ No Prognosis ☐ Yes ☐ No
Primary Interventions and Treatments Mandatory Field	Please outline previous interventions or treatments for symptoms related to the primary diagnosis below (For residents in retirement homes or other congregate settings please provide documentation that supports resident diagnosis and prognosis):
Care Issues (please check all that apply)	☐ EOL Care/Death Management ☐ Pain & Symptom Management Beds ☐ Disease Management ☐ Social Work ☐ Spiritual Care ☐ Psychological ☐ Loss & Grief (legacy work, anticipatory grief work) ☐ Encouraged Advance Care Planning Conversations between patient and Substitute Decision Maker ☐ Reviewed role of Substitute Decision Maker with the patient's SDM
	Is there a known patient goal to access Medical Assistance in Dying? ☐Yes ☐ No *If Yes, requires further conversations with receiving sites, please contact clinical resource nurse at receiving site.*

<table>
<tr><td>Discharge Potential
(only applicable for Pain & Symptom management)</td><td colspan="2">Could the patient return to their previous living arrangements if pain/symptoms were managed and identified goals were met?
Yes ☐
No ☐ What are the barriers for discharge to the previous living arrangements?

What are the alternate options?

☐ Patient/SDM are aware that if the symptoms stabilize, discharge planning will proceed.
Please provide specific details of the patient/SDM plan of care should the patient stabilize and discharge plans required :</td></tr>
<tr><td rowspan="6">Special care considerations
(please check all that apply and elaborate)

*Early consultation required for patients with oxygen greater than 6L/min to support safe transportation and oxygen delivery in the Hospice setting</td><td>☐ Allergies: ☐ Yes
☐ No known allergies (NKA)
Describe:</td><td>☐ Central line:
☐ IV:
☐ Pain pump:</td></tr>
<tr><td>☐ Diet:
☐ Tube feed:</td><td>☐ Wound:
☐ Drains:</td></tr>
<tr><td>☐ Hydration
☐ Transfusion</td><td>☐ Dialysis Run/day/time: _____
☐ Peritoneal dialysis
☐ Hemodialysis
Dialysis Discontinuation Date: _____

Review by renal team required:_____</td></tr>
<tr><td>☐ Oxygen: How many L/min____
Type of oxygen delivery system:
☐ N/P☐ Face Mask ☐ CIPAP ☐ BIPAP
☐ Nebulizer
☐ Tracheostomy: if √ please contact receiving site to review</td><td>☐ Ongoing treatment for symptom relief (Chemo, radiation, Dialysis):</td></tr>
<tr><td>☐ Cognition/Dementia Issues
Please identify risk behaviours:</td><td>☐ Pacemaker
☐ Internal defibrillator
Has it been deactivated ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">☐ Additional equipment required?</td></tr>
<tr><td colspan="3">RELEVANT ATTACHMENTS (please provide the following if not available to the receiving organization electronically) Please note that Hospice may not have access to clinical connect please provide the following</td></tr>
<tr><td colspan="3">☐ Most recent/relevant Patient History/Consultation reports
☐ Letter of Understanding
☐ MAR/Home Medication List
☐ Most recent Physician, Nursing, Allied Health Progress Notes</td></tr>
</table>

Palliative Care Hospice & In-Patient Letter of Understanding

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

Program Requested	Facility Requested
☐ Palliative Care	☐ Grand River hospital- Freeport, Kitchener ☐ Groves Memorial Hospital- Fergus ☐ St. Joseph's Health Centre- Guelph ☐ Hospice Wellington- Guelph ☐ Lisaard House- Cambridge ☐ Innisfree House- Kitchener ☐ Hospice Waterloo Region

I understand this means:

1. I have discussed the requested program with the referral source contact below

   _____. Referral Source contact #_____
   (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.

_____
Signature of Patient/Substitute Decision Maker Date: ☐ Consent obtained verbally

_____
Signature of Witness Date

_____
Name of Individual Obtaining Consent Date:

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How is Crisis defined?

A patient is considered to be "In Crisis" if:

1. Patient and/or caregiver safety is at risk and/or there is a risk that a significant health event and/or challenging end-of-life symptoms cannot be managed in their current setting
2. Patient at risk of requiring ED or acute care admission
3. Community resources have been exhausted and family/ caregivers are unable to cope with the patient's care needs
4. There is a risk that the services required to meet the patient's end-of-life care plan goals may not be available in their current setting
5. Patient at risk of not accessing their preferred place of death (considering recent trajectory of the PPS score).