

HOSPICE

REFERRAL FORM*

Palliative Care Community Team
Grief/Bereavement Services

Name _____ DOB _____ Gender M F : _____

MM/DD/YYYY

Address _____ Phone _____ - _____ - _____

Health Card# _____

Email: _____

<input type="checkbox"/> Kawartha Lakes Community Care City of Kawartha Lakes Tel: 705.879.4123 Fax: 705.880.0531	<input type="checkbox"/> Haliburton Haliburton Highlands Health Services Tel: 705.457.2941 Extension 2930 Fax: 705.457.4609	<input type="checkbox"/> Scarborough Scarborough Centre for Health Communities Tel: 416.847.4111 Fax: 416.261.0782	<input type="checkbox"/> Peterborough Hospice Peterborough Tel: 705.742.4042 Fax: 705.742.0064	<input type="checkbox"/> Northumberland Community Care Northumberland Tel: 1-855-473-8875 Fax: 289-252-0676	<input type="checkbox"/> Durham VON Canada – Ontario Region Tel: 905.240.4522 TF: 1.877.668.9414 Fax: 905.240.4533
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*NOTE: Referrals Reviewed Monday-Thursday: 9am - 4pm; Friday: 9am - 1pm

Service Type Requested

- Palliative Care Community Team Grief & Bereavement Caregiver Support Hospice Volunteer
 Palliative Pain & Symptom Mgmt Consultation/Clinic Other:

Referring Individual

Name: _____ Tel _____ - _____ - _____

Agency/Role: _____ Fax _____ - _____ - _____

Urgency

- <24 hours
 1-2 Business Days
 <1 Week
 1 Week
 1-2 Weeks
 >2 Weeks

PPS

(see reverse, if applic.)

- 100% 50%
 90% 40%
 80% 30%
 70% 20%
 60% 10%

Client Consent to Referral Yes No

Consent Given By: _____

Current Services in Place:

- CCAC Family Health Team Hospital
 Community Health Centre Hospice
 General Practitioner Oncologist
 Counsellor/therapist/psychol./psychiatry
 Other:

Substitute Decision Maker Information:

Name _____

Relationship to Client _____

Telephone (_____) _____ - _____

Call and speak with patient directly? Yes No _____

Address: Same as client, if not, insert ⇨

Primary Health Care Provider _____

Telephone (_____) _____ - _____

Comments:

Reason for Referral

Palliative Care

Date of Diagnosis _____ / _____ / _____ Prognosis _____ / _____
MM DD YYYY Months Weeks

Primary Diagnosis (& co-morbidities):

Is client aware of prognosis/diagnosis? Yes No

Is family aware of prognosis/diagnosis? Yes No

Resuscitation Status: DNR Discussed: Yes No Signed: Yes No

Grief / Bereavement

Name of Person Who Died: _____ Date of Death: _____

Nature of Death: _____ Relationship of Deceased to client: _____

Comments:

Caregiver Support

Name of Person caring for: _____ Relationship to this person: _____

Medical/psych. condition of the person they are caring for _____

Distress Exhaustion Overwhelm Requires respite Difficulty coping Other: _____

Comments:

Additional Comments:

* Please attach all supporting documents, tests results, or investigations with this referral *

**Palliative Performance Scale (PPSv2)
version 2**

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Converting Clinical Frailty Scale (CFS) and Palliative Performance Scale (PPS)	
Clinical Frailty Scale	Palliative Performance Scale
3-4	70-90
5	60
6	40-50
7	10-30
<p><i>Note:</i> CFS 1 and 2 and PPS 100 are not included in this conversion chart because data were unavailable for those scores.</p>	

Note: Sending in this referral form does not automatically mean the patient has been accepted for service.



Office Use Only

Date of Referral Received: _____ / _____ / _____

Date of First Contact: _____ / _____ / _____

Entered Into Database: _____ / _____ / _____

MM DD YYYY

Staff Initials: _____