HOSPICE
LENNOX & ADDINGTON

Palliative Care Referral

Referral Date _____

CLIENT INFORMATION

Name _____ Sex _____

Address _____

Primary Phone _____ Alternate Phone _____

Date of Birth _____ Health Card Number _____

EMERGENCY CONTACT

Contact Person _____ Relation to Client _____

Primary Phone _____ Alternate Phone _____

MEDICAL INFORMATION

Family Physician _____ Phone _____

Life Limiting Diagnosis

- ❑ ALS
- ❑ Cancer
- ❑ COPD
- ❑ Dementia
- ❑ Heart Disease
- ❑ HIV/Aids
- ❑ Unknown
- ❑ Other _____

Client Aware of Diagnosis?

- ❑ Yes
- ❑ No
- ❑ Unknown

PPS _____

Prognosis _____

Diagnosis Details and History

SERVICES

Services requested or suggested

- ❑ Bereavement Support
- ❑ Respite
- ❑ Case management
- ❑ Palliative psych/social
- ❑ Visiting volunteer – one on one

Other organizations involved with client

- ❑ ALS
- ❑ Cancer Society
- ❑ Cancer Support Center
- ❑ Community Care
- ❑ Dietician
- ❑ Nursing
- ❑ CCAC
- ❑ Homemaking Agency
- ❑ Occupational Therapist
- ❑ Palliative Care Team
- ❑ Physiotherapist
- ❑ Respite Service
- ❑ Social Work
- ❑ Spiritual
- ❑ Other _____

Current Dwelling

- ❑ House
- ❑ Apartment
- ❑ Hospital
- ❑ Long-term care
- ❑ Other _____

REFFERAL INFORMATION

Referred by _____

Contact number _____

Client Consents to referral?

- ❑ Yes
- ❑ No
- ❑ Unknown

Source

- ❑ Self
- ❑ Family
- ❑ Friend
- ❑ Agency. Please specify:

_____

_____

Please note any special considerations below.

For office use only

Entered into *InfoAnywhere* ❑ Client number: _____