HOSPICE
LENNOX & ADDINGTON

Palliative Care Referral Form

Referral Date _____

CLIENT INFORMATION

Name _____ Sex _____

Address _____

Phone (home) _____ (cell/other) _____

Date of Birth _____

Health Card Number _____

EMERGENCY CONTACT

Contact Person _____ Relation to Client _____

Phone (home) _____ (cell/other) _____

MEDICAL INFORMATION

Life Limiting Diagnosis:

- ❑ ALS
- ❑ Cancer
- ❑ COPD
- ❑ Dementia
- ❑ Heart Disease
- ❑ HIV/Aids
- ❑ Unknown
- ❑ Other, please describe: _____

History of Present Illness/Notes/Special considerations:

_____

_____

_____

_____

_____

PPS level:

- ❑ 100
- ❑ 90
- ❑ 80
- ❑ 70
- ❑ 60
- ❑ Other, please specify: _____
- ❑ Unspecified

Client Aware of Diagnosis?

- ❑ Yes
- ❑ No
- ❑ Unknown

Prognosis (days, weeks, months, years, unknown): _____

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, please specify: _____

Dwelling:

- ❑ House
- ❑ Apartment
- ❑ Hospital
- ❑ Nursing Home

FAMILY PHYSICIAN

Physician Name Phone Number

REFFERAL INFORMATION

Referred by

Source (CCAC/Spouse/Family/Other specify)

Agency & Position Phone

NOTES