HOSPICE
LENNOX & ADDINGTON

Palliative Care Referral

Please fax completed form to **613-354-8233**
*If referral coming from Ontario Health atHome, please attach patient summary if available
.

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
- ❑ Cancer
- ❑ COPD
- ❑ Dementia
- ❑ Heart Disease
- ❑ Other _____

Client Aware of Diagnosis?
- ❑ Yes
- ❑ No
- ❑ Unknown

PPS _____

Diagnosis Details and History

SERVICES

Services requested or suggested

- ❑ Visiting volunteer
- ❑ Emotional/spiritual support
- ❑ Equipment loan
- ❑ Resources
- ❑ Check-ins
- ❑ System navigation/case management
- ❑ Respite
- ❑ EOL & ACP
- ❑ Pain & symptom management

Current Dwelling

- ❑ Alone
- ❑ Spouse/Partner
- ❑ Family/Friends
- ❑ Long-term care home
- ❑ Hospital
- ❑ Retirement home
- ❑ Other _____

REFFERAL INFORMATION

Referred by _____

Contact number _____

Source

- ❑ Self
- ❑ Family/friend
- ❑ Care Coordinator
- ❑ LACGH
- ❑ Agency. Please specify:

_____

_____

Please note any special considerations below.