

# PROVIDENCE CARE HOSPITAL PALLIATIVE CARE REFERRAL

This form is designed to be filled out electronically, then e-mailed (KGH only), or printed and faxed to Providence Care. The option of printing and filling it out by hand does exist. If when filling the form out by hand you determine that there is not enough room on the form for you to elaborate, please include your further information on another sheet of paper at the end of the referral form.

**Note: If you are including additional pages to this form, remember to include the surname, first name and date of birth (D.O.B) up in the top right hand corner and the number of pages to show the total number of pages to be received in the package.**

**Admission Criteria:**

	Short Term Palliation	Long Term Palliation
<b>Prognosis</b>	Palliative Performance Scale (PPS) of 50% or less and expected prognosis of < 3-4 months; with no resuscitative effort and no escalation of care except to enhance comfort. A person with a PPS of < 10 will be considered on a case-specific basis.	Palliative Performance Scale (PPS) of 50% or less and life expectancy of 4-12 months, focused on palliation with no resuscitative effort at death.
<b>Treatment</b>	The established treatment regime focuses on pain and symptom management and end of life care.	Escalation of medical care only for the purpose of improving symptom management. The potential for return to community exists.
<b>Type of Service</b>		
Provides care to patients with a life limiting illness at the end of life stage of that disease process who are not requesting resuscitation, who require pain and symptom management and skilled interventions delivered by an inter-professional team.		
Provides services to both short and long term palliative patients. There may be exceptions to criteria such as referrals from community for symptom management.		

Referral completed by: \_\_\_\_\_  Referring Service Provider has discussed the purpose of this referral and the goals of care with the patient.

Title: \_\_\_\_\_

Unit: \_\_\_\_\_

Telephone/Pager: \_\_\_\_\_

**Only KGH:** Please complete and send electronically to [servicereferrals@providencecare.ca](mailto:servicereferrals@providencecare.ca) (ProvCare, Inpatient Service Referrals)

**FOR ALL OTHER REFERRAL SOURCES: Please Fax to Central Intake at: (613) 548-5595**

Please attach the following with this referral:

- Medical Administration Record (MAR)
- Relevant Interprofessional Assessments/Progress Notes
- DNRc Form

Indicate Referral Destination:  Short Term Palliation  
 Long Term Palliation

**Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral**

## PROVIDENCE CARE HOSPITAL PALLIATIVE CARE REFERRAL

Intake Assessor and referring clinician discussed with Patient/Family/POA and documented:

- Advance Care Planning discussions confirming resuscitation not to be pursued
- Providence Care, guided by our Mission and Values, as a Catholic sponsored health care organization, does not provide the act of (MAID) medical assistance in dying, (physician assisted death/assisted suicide/voluntary euthanasia) but will assure that a patient's request for MAID is acknowledged and appropriately addressed.

Patient Details and Demographics			
Health Card Number:		Version Code:	
Surname:		Given Names:	
Home Address:		City:	Province:
Postal Code:		Telephone:	Cell:
Current Location: <input type="checkbox"/> Home <input type="checkbox"/> Residential Hospice <input type="checkbox"/> Other (specify address): _____ <input type="checkbox"/> Hospital _____			
Anticipated hospital discharge date: (YYYY/MM/DD):			
Date of Birth: (YYYY/MM/DD):		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: _____	Marital Status:
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____			
Power of Attorney for Personal Care, if known:			
Family/Informal Caregivers:			
Name	Relationship	Home Phone	Business /Cell Phone

Reason for Referral /Goals of Care (select all that apply):	
<input type="checkbox"/> End of Life Care – EOL (last days to weeks)	<input type="checkbox"/> Patients from community for symptom management with potential discharge
<input type="checkbox"/> Patient or family do not wish home death	<input type="checkbox"/> Symptom management and EOL care
<input type="checkbox"/> Other	
Details:	
Medical Information	
Primary Health Care Provider:	Phone: _____ Fax: _____
Admission Date (YYYY/MM/DD): (if applicable)	
Primary Palliative Diagnosis: (Life threatening illness)	<b>Palliative Performance Scale (PPS) Score:</b> _____ (see Appendix A)
History of Presenting Illness/Course in Hospital:	
Date of Diagnosis (terminal illness) (YYYY/MM/DD):	
Does the patient have cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary site:
Tissue type confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Metastatic Sites:	
Summary of treatments (e.g. chemo, radiation, dialysis):	

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Noteworthy complications of main diagnosis (i.e. spinal cord compression, delirium):							
Other Concurrent Illnesses:							
Noteworthy Past Medical History:							
<b>Allergies:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If Yes, list known adverse medication reactions			
Infection Control: <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> Other (Specify) _____							
Height: <input type="checkbox"/> Inches <input type="checkbox"/> Cm				Weight: <input type="checkbox"/> Pounds <input type="checkbox"/> Kg			
<b>Psychosocial Situation</b>							
<input type="checkbox"/> Patient and/or family coping difficulties				<input type="checkbox"/> Substance abuse			
<input type="checkbox"/> Patient lives alone				<input type="checkbox"/> Psychiatric issues			
<input type="checkbox"/> Caregiver stress, illness				<input type="checkbox"/> Behavioural issues			
<input type="checkbox"/> Family tension				<input type="checkbox"/> Social isolation			
<b>Please provide details:</b>							
<b>Advance Care Planning (select all that apply)</b>							
DNR: <input type="checkbox"/> Yes <input type="checkbox"/> No * Patients require a DNR order to be admitted to Providence Care's Palliative Care Unit							
If No, please explain: <input type="checkbox"/> Discussion has not occurred <input type="checkbox"/> Patient requests full code <input type="checkbox"/> Full Code is appropriate				If Yes, please select: <input type="checkbox"/> DNR Discussed and Confirmed With Patient/SDM <b>* Please forward DNR confirmation form at time of transfer</b>			
Advanced Care Directives: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Date of most recent discussion (YYYY/MM/DD):							
<b>Symptoms: Edmonton Symptom Assessment Scale (ESAS)</b>							
Who completed the ESAS?				Date Completed (YYYY/MM/DD):			
If no, what is the reason? <input type="checkbox"/> Patient too ill (PPS<30%) <input type="checkbox"/> Language barrier <input type="checkbox"/> Cognitively impaired/Delirious <input type="checkbox"/> Other							
0 indicates the symptoms is absent, while 10 is the highest severity of the problem.							
<b>ESAS Scores (please indicate score on the scale of 0 to 10)</b>							
Pain:	Fatigue:	Nausea:	Depression:	Drowsy:	Appetite:	Feeling of well-being:	Shortness of Breath:
Please describe most active symptoms:							
Please describe other symptoms (including physical, psychological, spiritual, religious, social, existential):							
<b>Swallowing and Intake</b>							
Swallowing difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No				Current diet order/ Dietary restrictions:			
Intake: <input type="checkbox"/> Normal <input type="checkbox"/> Reduced <input type="checkbox"/> Sips Only <input type="checkbox"/> NPO							
<b>Equipment &amp; Special Care Needs</b>							
<input type="checkbox"/> Transfusion		Hydration Type: <input type="checkbox"/> SC or <input type="checkbox"/> IV		<input type="checkbox"/> CADD <input type="checkbox"/> Epidural		Enteral feeds Type/Brand of Feed: Route: <input type="checkbox"/> PEG <input type="checkbox"/> PEJ <input type="checkbox"/> N/G <input type="checkbox"/> Bolus <input type="checkbox"/> Continuous	
<input type="checkbox"/> Hemodialysis		<input type="checkbox"/> Central line		<input type="checkbox"/> P.I.C.C. line		<input type="checkbox"/> Tracheostomy Size _____ Brand _____	
<input type="checkbox"/> PortaCath		<input type="checkbox"/> Thoracentesis		<input type="checkbox"/> Paracentesis		<input type="checkbox"/> Oxygen rate _____	
<input type="checkbox"/> Drains/Catheter (specify) _____				<input type="checkbox"/> NP <input type="checkbox"/> Mask			
<input type="checkbox"/> Therapeutic Surface (specify) _____							
<input type="checkbox"/> Other Needs _____							

## PROVIDENCE CARE HOSPITAL PALLIATIVE CARE REFERRAL

Skin Condition					
Surgical Wounds and /or Other Wounds Ulcers: <input type="checkbox"/> Yes <input type="checkbox"/> No					
1. Location:			Stage:		
• Dressing Type (e.g. Negative Pressure Wound Therapy or VAC)			Frequency:		
• Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes					
2. Location:			Stage:		
• Dressing Type (e.g. Negative Pressure Wound Therapy or VAC)			Frequency:		
• Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes					
Elimination Device		Supplies required			Date of last change
Colostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Ileostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Nephrostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Ileo-conduit	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Current Functional Status					
Sitting Tolerance:	<input type="checkbox"/> More than 2 Hours Daily	<input type="checkbox"/> 1-2 Hours Daily	<input type="checkbox"/> Less Than 1 Hour Daily	<input type="checkbox"/> Has not Been Up	
Transfer:	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assist x1	<input type="checkbox"/> Assist x2	<input type="checkbox"/> Mechanical Lift
Ambulation:	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assist x1	<input type="checkbox"/> Assist x2	<input type="checkbox"/> Mechanical Lift
Equipment Required					

**\*A copy of the Medical Administration record (MAR) and the physician's Discharge Summary must accompany the patient at the time of transfer. \*A copy of DNR must accompany Patient to Providence Care**

**PROVIDENCE CARE HOSPITAL  
PALLIATIVE CARE REFERRAL**

**Appendix "A"**

**Palliative Performance Scale (PPS)**

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

**Edmonton Symptom Assessment Scale (ESAS)**

0 indicates the symptoms is absent, while 10 is the highest severity of the problem.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not Tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible Tiredness
Not Nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible Nausea
Not Depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible Depression
Not Anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible Anxiety
Not Drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible Drowsiness
Best Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible Appetite
Best Feeling of Wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible Feeling of Wellbeing
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible Shortness of Breath

**ABBREVIATIONS**

- CDIFF - Clostridium difficile
- MRSA - Methicillin-resistant Staphylococcus aureus
- VRE - Vancomycin-resistant Enterococci
- ESBL - Extended Spectrum Beta Lactamase
- TB - Tuberculosis
- CADD - Continuous Ambulatory Delivery Device - for Subcutaneous Infusion
- PEG - Percutaneous Endoscopic Gastrostomy
- PEJ - Percutaneous endoscopic jejunostomy
- NG - nasogastric tube