Providence Care

PALLIATIVE CARE REFERRAL

PERSONAL HEALTH INFORMATION

INTRODUCTION

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
Prognosis	Palliative Performance Scale (PPS) of 50% or less and expected prognosis of less than three (3) 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.
Treatment	The established treatment regime focuses on pain and symptom management and end of life care.
Type of Service	
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.	

Referral completed by: ____________________

Title/Unit: ____________________

Telephone/Pager: ____________________

Only KGH: Please complete and send electronically to servicereferrals@providencecare.ca

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

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

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Intake Assessor - Discussed with Patient/Family/POA:

☐ 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: ☐ Home ☐ Residential Hospice

☐ Other (specify address): ____

☐ Hospital ________________________________

Anticipated hospital discharge date: (YYYY/MM/DD):________________

Date of Birth: (YYYY/MM/DD):	Gender: ☐ Male ☐ Female ☐ Other:	Marital Status:

Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ 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):

☐ End of Life Care – EOL (last days to weeks)

☐ Patient or family do not wish home death

☐ Other

☐ Patients from community for symptom management with potential discharge

☐ Symptom management and EOL care

Details:

Medical Information		
Primary Health Care Provider:	Phone:	Fax:
Admission Date (YYYY/MM/DD): (if applicable)		
Primary Palliative Diagnosis: (Life threatening illness)	**Palliative Performance Scale (PPS) Score**:________ (see Appendix A)	
History of Presenting Illness/Course in Hospital:		

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Medical Information (cont'd)

Date of Diagnosis (terminal illness) (YYYY/MM/DD):

Does the patient have cancer? ☐ Yes ☐ No Primary site:
Tissue type confirmed: ☐ Yes ☐ No
Metastatic Sites:

Summary of treatments (e.g. chemo, radiation, dialysis):

Noteworthy complications of main diagnosis (i.e. spinal cord compression, delirium):

Other Concurrent Illnesses:

Noteworthy Past Medical History:

Allergies:
☐ Yes ☐ No ☐ Unknown

If Yes, list known adverse medication reactions

Infection Control: ☐ None
☐ Methicillin-resistant Staphylococcus aureus (MRSA)
☐ Vancomycin-resistant Enterococci (VRE)
☐ Clostridium difficile (CDIFF)
☐ Extended Spectrum Beta Lactamase (ESBL)
☐ Tuberculosis (TB)
☐ Other (Specify):

Height: ☐ Inches ☐ cm
Weight: ☐ Pounds ☐ Kg

Psychosocial Situation

☐ Patient and/or family coping difficulties
☐ Patient lives alone
☐ Caregiver stress, illness
☐ Family tension
☐ Substance abuse
☐ Psychiatric issues
☐ Behavioural issues
☐ Social isolation

Please provide details:

Advance Care Planning (select all that apply)

DNR: ☐ Yes ☐ No ***Patients require a DNR order to be admitted to Providence Care's Palliative Care Unit***

If No, please explain:
☐ Discussion has not occurred
☐ Patient requests full code
☐ Full Code is appropriate

If Yes, please select:
☐ DNR Discussed and Confirmed With Patient/SDM
* ***Please forward DNR confirmation form at time of transfer***

Advanced Care Directives: ☐ Yes ☐ No ☐ Not Sure
Date of most recent discussion (YYYY/MM/DD): __________________

Symptoms: Edmonton Symptom Assessment Scale (ESAS)

Who completed the ESAS?
Date Completed (YYYY/MM/DD):____________________

If no, what is the reason?
☐ Patient too ill (PPS<30%) ☐ Language barrier ☐ Cognitively impaired/Delirious ☐ Other

0 indicates the symptoms is absent, while 10 is the highest severity of the problem.
ESAS Scores (please indicate score on the scale of 0 to 10)

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):

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Swallowing and Intake	
Swallowing difficulty	☐ Yes ☐ No Current diet order/ Dietary restrictions:
Intake: ☐ Normal ☐ Reduced ☐ Sips Only ☐ NPO	

Equipment & Special Care Needs			
☐ Transfusion	☐ Hydration Type: ☐ SC or ☐ IV	☐ CADD ☐ Epidural	☐ Enteral feeds Type/Brand of Feed: ☐ Route: ☐ PEG ☐ PEJ ☐ N/G ☐ Bolus ☐ Continuous
☐ Hemodialysis	☐ Central line	☐ P.I.C.C. line	
☐ PortaCath	☐ Thoracentesis	☐ Paracentesis	☐ Tracheostomy Brand______ Size _________

☐ Drains/Catheter (specify) ____________________________________

☐ Therapeutic Surface (specify) ________________________________

☐ Other Needs ____

☐ Oxygen rate _____________ ☐ NP ☐ Mask

☐ Drains/Catheter (specify) ____________________________________

☐ Therapeutic Surface (specify) ________________________________

☐ Other Needs ____

☐ Oxygen rate ____________ ☐ NP ☐ Mask

Skin Condition	
Surgical Wounds and /or Other Wounds Ulcers: ☐ Yes ☐ No	
1. Location:	Stage:
• Dressing Type (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
• Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes	
2. Location:	Stage:
• Dressing Type (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
• Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes	

Elimination Device		Supplies required	Date of last change
Colostomy	☐ Yes ☐ No		
Ileostomy	☐ Yes ☐ No		
Nephrostomy	☐ Yes ☐ No		
Ileo-conduit	☐ Yes ☐ No		

Current Functional Status					
Sitting Tolerance:	☐ More than 2 Hours Daily	☐ 1-2 Hours Daily	☐ Less Than 1 Hour Daily		☐ Has not Been Up
Transfer:	☐ Independent	☐ Supervision	☐ Assist x1	☐ Assist x2	☐ Mechanical Lift
Ambulation:	☐ Independent	☐ Supervision	☐ Assist x1	☐ Assist x2	☐ 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***

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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**
☐	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 *with* 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 Significant 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 Significant disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
☐	20%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
☐	10%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Mouth care only	Full or Coma +/- Confusion
☐	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