Presentation Centre | 3 St. Catherine Street | Grand Falls-Windsor, NL
A2A 1V7 | t: 709.489.1222 | w: lionelkellandhospice.ca
Fax: 709.489.2523 Email: care@lionelkellandhospice.ca

FIRST NAME: ____________________ **LAST NAME:** ____________________

DOB (D/M/Y): ____________________ **MCP**: ____________________

RESIDENT REFERRAL REQUEST

All fields must be completed. Incomplete referrals will be returned and could delay admission.

GENERAL INFORMATION

Home Address:	Phone Number:	Alternate Number:
Gender:	Preferred Language: □ English □ French	□ Other (specify):

RESIDENT CAPACITY and CONTACTS

□ Individual is **capable** of making health care decisions		
□ Individual has a designated POA-Power of Attorney for Health Care Decisions		
Name:	Phone:	Relationship:
□ Substitute Decision-Maker or Next of Kin Contact Details		
Name:	Phone:	Relationship:

REFERRAL INFORMATION

Referred by:	Phone:	
Primary Care Provider:	Phone:	***Return Fax #:**

LOCATION OF INDIVIDUAL

□ Home	□ Lives Alone	□ Personal Care Home	□ Hospital	□ Other
Facility Name:				
□ Followed by the Palliative Care Program		Consultant's Name:		

ESTIMATION OF PROGNOSIS

□ **Less than 30 days** □ **Less than 60 days** **(PPS) Palliative Performance Scale:** %	
□ Individual aware of prognosis?	□ Family aware of prognosis?
□ DNR Completed *Copy of DNR must be sent with referral*	
□ Current List of Medications *Current List of Medications must be sent with referral*	

RESIDENT REFERRAL REQUEST

*MEDICAL INORMATION

End Stage of Diagnosis:
Attach any relevant medical information required for providing care.

LIONEL KELLAND HOSPICE
CARE • RESPECT • DIGNITY

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FIRST NAME: ____________________ **LAST NAME:** ____________________

DOB (D/M/Y): ____________________ **MCP**: ____________________

*RESIDENT CARE NEEDS

Conscious Level: ☐ Alert & Oriented ☐ Confusion ☐ Drowsy ☐ Coma
Ambulation: ☐ Mainly Sit/Lie ☐ Mainly in Bed ☐ Totally Bed Bound
☐ Tracheostomy Size & Brand: Frequency of Suctioning:
☐ NG or G-Tube (Gastrostomy Tube) Purpose:
☐ Urinary Catheter
☐ Ostomy ☐ Colostomy ☐ Ileostomy ☐ Nephrostomy ☐ Ileoconduit

☐ Oxygen Litre Flow: ☐ Nasal Prongs ☐ Mask ☐ Other
☐ CADD/PCA Infusion
☐ ICD-Implanted Cardiac Defibrillators
☐ Wound Care Site(s): Dressing Type & Frequency:
☐ Dysphagia
Special Diet/Swallowing Instructions:
Diet Type: