

General Information

First Name: Last Name:
DOB (dd/mm/yyyy): MCP:
Address:
Town, Province: Postal Code:
Phone Number: Alternate Number:
Gender: Male Female Other Preferred Language: English French Other

Resident Capacity and Contacts

Individual is capable of making health care decisions Yes No

Individual has a designated POA-Power of Attorney for Health Care Decisions, If yes, please list: Yes No

Name: Relationship:
Phone:

Substitute Decision-Maker or Next of Kin Contact Details

Name: Relationship:
Phone:

Referral Information

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

Location of Individual

Location: Home Lives Alone Personal Care Home Hospital Other

Facility Name:

Followed by Palliative Care Team: Yes No Consultant:

General Information

First Name: Last Name:
DOB (dd/mm/yyyy): MCP:

Estimation of Prognosis

- Less than 30 days Less than 60 days Palliative Performance Scale (PPS) : %
- 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*

Medical Information

End Stage of Diagnosis:

Attach any relevant medical information required for providing care.

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 Sites:
- Dressing Type & Frequency:
- Dysphagia
- Special Diet/Swallowing Instructions:
- Diet Type: