Community Palliative Medicine Associates
Referral Form

IF REFERRAL IS URGENT, CONTACT OUR ADMINISTRATIVE ASSISTANT AT:
613-801-0035, EXT. 200

Criteria for care by our group:

- Must have a life-limiting illness which is actively progressing and requires symptom management and /or end of life care
- Prognosis has been discussed with patient/POA
- Palliative Performance Scale (PPS) <= 50%
- Must have a CCAC Palliative Care Coordinator and a chart in the home
- Must have adequate support to be maintained at home, at least initially
- Must have a signed MD referral **with accessible return contact information**

Please ensure the following are completed BEFORE faxing referral to 613-801-0036 (incomplete referrals will be returned without review):

- ☐ All four sections of referral form are completed. If referring MD is unable to complete all sections, consider contacting CCAC Care Coordinator to provide details
- ☐ Attach most recent consult/clinic notes, first note for life limiting illness, relevant imaging reports and recent hospital discharge summary. It is the referring source's responsibility to provide this information to ensure timely consideration
- ☐ Family Physician must be notified regarding referral and agree to referral to CPMA
- ☐ **Please ensure a direct fax number is provided so we can notify you regarding acceptance of this referral**

For details on our coverage area please see our website:
www.cpmaottawa.ca

IMPORTANT NOTES FOR REFERRALS OF HOSPITAL INPATIENTS:

- ☐ Consider phone contact between attending physician or palliative care physician and CPMA **early** in the discharge planning process.
- ☐ Inpatient palliative care consultation is **strongly recommended.**
- ☐ **Prior to discharge**, ensure that patient has adequate supplies in place at home:
  - injectable medications (**fax Rx to Medical Pharmacies, 613-244-4695, not retail pharmacy**)
  - supplies for subcutaneous drug administration, urinary catheter, wounds, etc.
  - equipment such as hospital bed, commode, wheelchair
- ☐ Complex patients should have a nursing visit at home on the day of discharge.
- ☐ Request that CCAC transfers patient to the Palliative Care Team upon discharge.
- ☐ Give adequate notice to CPMA physician of projected discharge date and **confirm discharge by phone on date of discharge. Care is not assumed until patient is seen by CPMA.**
- ☐ **Patients who have been accepted onto to our service who are discharged on Friday/Saturday cannot have their care assumed by CPMA until the following week.**
- ☐ The discharge summary, including medication list, should be faxed to CPMA at or before discharge.

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Note that if you are using a patient label, please ensure that
the information on the label pertains to the **address where care is to be delivered.**

Section 1: Patient Demographics:

Name:

Gender: Male ☐ Female ☐

Date of Birth:

Health Card # with VC:

Address where care is to be delivered:

Street Address:

City:

Postal Code:

Phone # at site of care:

Does patient live alone? ☐ Yes ☐ No

Main caregiver name:

Relationship:

Caregiver Phone#:

Language spoken:

If not English, is an interpreter required & available? ☐ Yes ☐ No

Current location if not home:

If in hospital, approx. date of discharge:

Power of Attorney

POA for Personal Care:

POA Contact information:

Caregiver/Physician Details

Family Physician:

Date of contact with Family Physician:

Does family physician wish to share care of patient at home?

** Please note the family physician must be contacted and agree to CPMA referral*

Referring physician:

_____ _____ _____

Print name | Signature of referring physician | OHIP Billing Number

MANDATORY: Private Line/Cell Phone/Pager: _____ **Direct Fax number:** _____

Other physicians involved in patient's care:

CCAC Palliative Care Coordinator name/extension:

Patient or POA must consent to CPMA referral and release of information.

Please have patient or POA sign below:

I understand that _____ has been referred for home palliative care by Community Palliative Care Associates (CPMA) and I authorize any organization to release any personal health information requested by CPMA required to facilitate this referral and subsequent care.

_____ _____

Signature of patient/POA for personal care | Name of patient/POA for personal care

Section 2: Palliative Issues

Life-limiting diagnosis: Date of original diagnosis/pathology report:

Reason for referral: *What are the current problems/needs of the patient/family? What are the major symptoms currently being experienced and/or managed?* ***Why is the patient being referred at this time?***

Current disease status:

☐ Stable ☐ Progressing ☐ Deteriorating rapidly ☐ Deteriorating slowly ☐ Other: _____

Future treatments planned:

Estimated prognosis:

Functional Status:

Current Palliative Performance Scale (PPS): _____

For PPS, see: www.cpmaottawa.ca/PPS.pdf

Is functional status: *(Check appropriate description)*

☐ Stable
☐ Declining

If declining, is it declining…Daily ☐ *Weekly* ☐ *Monthly* ☐

Please provide the approximate number of hours spent:

In bed: *In chair:* *Activity:* *Sleeping:*

Goals and Plan of Care:

Patient and relative/caregiver understanding of diagnosis/prognosis/treatment:

What are the goals of care?

Would the patient want to return to hospital to investigate and/or treat exacerbations or complications of their underlying condition?

Has there been discussion regarding discontinuing life-prolonging therapies such as:
Dialysis, hydration, transfusions, implanted Cardioverter-defibrillators, antibiotics, other? ☐ Yes ☐ No

What were the results of these discussions?

What are the current resuscitation directives?

At the current time, what is the planned location for end of life care: ☐ Home ☐ Hospice ☐ Hospital

Any other issues which would affect urgency of CPMA involvement:

Section 3: Other Medical Issues

Other significant medical conditions:

Attach a current list of medications Allergies:

Please list any drains/catheters/ostomies/oxygen/respiratory support equipment etc.:

Are you aware of any infection control issues (MRSA/VRE/C. difficile/bloodborne pathogens, etc.)?

Other relevant information (including mobility/access/mental capacity issues):

Section 4: Place of Care Issues

Are you aware of any safety issues that could affect the ability to provide care in the home?

Are you aware of any substance abuse or psychiatric issues in the home?

Are you aware of any other caregiver issues that could affect the ability to provide care in the home?

We appreciate and thank you for your cooperation in fully completing this form.

Please fax completed form to: 613-801-0036

Incomplete forms will be returned to you

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