

Hospice Peterborough & Peterborough Palliative Physicians Referral Form

<input type="checkbox"/> Palliative Physician	Palliative Physician Consultation <input type="checkbox"/> First Available <input type="checkbox"/> Dr. J. Beamish <input type="checkbox"/> Dr. M. Gibson <input type="checkbox"/> Dr. J. Mallory <input type="checkbox"/> Dr. C. Matheson <input type="checkbox"/> Dr. A Morelli <input type="checkbox"/> Dr. N. Whiting <input type="checkbox"/> Michael Bernard, NP
<input type="checkbox"/> Hospice Services	<input type="checkbox"/> Palliative Care Community Team (PCCT) <input type="checkbox"/> Other Hospice Services
<input type="checkbox"/> Hospice Residence	<input type="checkbox"/> Client is in the approximate last 2 weeks of life <input type="checkbox"/> Client is to be considered for future admission
Statement	The client consented to a referral to Hospice Peterborough for the purpose of: <input type="checkbox"/> Consult with Palliative Physician <input type="checkbox"/> Participation in Hospice programs/services/residence

Palliative Client	Contact
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PPS: <input type="checkbox"/> 90% <input type="checkbox"/> <input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> <input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> <input type="checkbox"/> 40% <input type="checkbox"/> 30% <input type="checkbox"/> <input type="checkbox"/> 20% <input type="checkbox"/> 10% <input type="checkbox"/> Resuscitation status: <input type="checkbox"/> DNR Discussed <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____ DOB: ____ / ____ / ____ Gender: ____ Address: _____ Telephone: _____ OHIP#: _____ VC _____	Name: _____ Relationship to client: _____ Telephone: _____ Please specify who to contact regarding referral <input type="checkbox"/> Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Family
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Additional information to be included if not already a client of Hospice	Primary Diagnosis (& co-morbidities): <i>*Please attach any supporting documentation - clinical notes, investigations, recent medication list, etc.*</i> Is client/family aware of prognosis/diagnosis? Client: <input type="checkbox"/> Yes <input type="checkbox"/> No Family: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Diagnosis: ____ / ____ / ____ Prognosis: ____ Months ____ Weeks <div style="text-align: center; font-size: small;"> DD MM YYYY </div>
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Current Services in Place	<input type="checkbox"/> LHIN Home & Community Care <input type="checkbox"/> Family Health Team <input type="checkbox"/> Cancer Treatment Centre(name) : _____ <input type="checkbox"/> Other: _____
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Referring Individual Referring Health Care Provider: _____ Tel: _____ Fax: _____ Client's Family Physician: _____ OHIP Billing #: _____	
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Due to COVID-19 legislation, we will be accepting referrals for admission to the Residence on a case by case basis. Everyone will be screened upon entry to the building. At this time, visitors are limited.

Please fax to: 705-742-0064
 Questions? Please call Hospice Peterborough's Intake Coordinator: 705-742-4042

Eligibility Criteria for Admission:

- Require end of life care in the last weeks of life- prognosis days to weeks.
- Palliative Performance Scale of 30% or less or rapid decline in performance scale
- Established plan of care with no further investigations planned
- Expected length of stay 2 weeks or less
- Client or substitute decision maker consents to admission and has knowledge of the residence guidelines
- DNR