Hospice Peterborough Palliative Pain and Symptom Management Consultant (PPSMC) Referral

Urgency of Referral: 1= Stat (24 hours) 2= Urgent (1 week) 3= Routine Involvement (Specify_____)

1. Please fill in and complete all sections of the form, provide as much information as possible.
2. **Email** to ppsmc@hospicepeterborough.org or **Fax** to 705-742-0064
3. The PPSMC will provide recommendations (via In Person, Telephone, Email)
4. Once the recommendations / suggestions have been considered by your team and measures initiated as appropriate, please advise what has been done and the efficacy.

IMPORTANT* This is NOT an emergency service.

Date of Consult Request		
Health Care Provider Requesting Email Consult	Name:	Contact Email: Telephone:
Consent for Consult	Consent obtained from: □ Individual □ SDM / POA	
Personal Contact		Telephone:
Family Physician		Telephone:
Specialist		Telephone:
Palliative Physician		
Consult Type	□ Pain Management	□ Symptom Management
	□ Palliative Care	□ End of Life Care
Reason for Consult Please provide a brief description of the pain and/or symptoms being experienced by the individual		

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Client Name:	**Age:**
Address:	**Room Number:**
Diagnoses (all known):	**Allergies:**
Have advance care planning and goals of care discussions been initiated? □ No □ Yes **If yes, what are the current goals of care?**	
PPS: Please describe functional capabilities of individual	**Pain Score:** Verbal (ESAS) – PAINAD –
Medications	□ **Please attached MAR**
Issues or Challenges	

For Office Use Only

Date Referral Rec'd: _____ _____ Response Date:_____

Dates of Visit:_____

(Email, Face to face, Telephone, Fax, teleconference)

Referral Source: _____

Family, Palliative Care, CCAC, Physician, LTC, Oncology, Nursing

Consultation Contact : _____

Service Provider Contact number