Shirley and Jim Fielding Northeast Cancer Centre
Health Sciences North
Centre de cancérologie du Nord-Est Shirley et Jim Fielding
Horizon Santé-Nord

Ontario Health atHome

Maison McCulloch Hospice

SUDBURY SPECIALIZED PALLIATIVE CARE TEAM REFERRAL

Fax referral to Ontario Health atHome North East: 705-522-3855

BOLD FIELDS ARE MANDATORY

SECTION A – ELIGIBILITY CRITERIA

☐ **Patient meets eligibility criteria**

- **Life expectancy of 12 months or less.** *NOTE: non-oncological patients should fall within the definitions included in the Gold Standard Framework*
- **Client consents to referral to Palliative Care**
- **Adult 19 years or older**
- **Resides or has family who reside in the City of Greater Sudbury.** ***NOTE:*** *Consultative service available for out-of-town patients who meet all other criteria*
- **Require referral from Physician or Nurse Practitioner**
- **Pediatric End of Life Beds: 18 months to 18 years old**

SECTION B – GENERAL INFORMATION

Name: _____ **DOB**(yyyy/mm/dd):_____ Age: ____ **Gender:** _____
Phone: _____ **Address**:_____
City: _____ **Province:** _____ **Postal Code**: _____
Ontario Health Card #: _____ **Version Code**: _____
Family Physician/NP:_____ Preferred Language: ☐ English ☐ French ☐ Other:
Marital Status:_____ Lives Alone: ☐Yes ☐No Present location of client: ☐ Home ☐ Hospital Unit ☐ Unknown
Primary Contact, if other than patient: Name:_____ Phone: _____
Relationship: _____
SDM or POA if different than primary contact: ☐Yes ☐No ☐N/A Name:_____ Phone: _____
Relationship: _____

SECTION C – DIAGNOSIS & PROGNOSIS ESTIMATION

End stage diagnosis/diagnoses (*Please include any relevant reports not available in EMR):*

_____

Date of Diagnosis/Prognosis (yyyy/mm/dd): _____ ☐ Oncological ☐ Non-Oncological
Client able to attend outpatient clinic? ☐ Yes ☐ No **PPS: _____%**
Prognosis is: ☐ Less than 12 months ☐ Less than 6 months ☐ Less than 3 months ☐ Less than 1 month
Client aware of diagnosis and prognosis? ☐Yes ☐No Family aware of diagnosis and prognosis? ☐Yes ☐No

SECTION D – SERVICE(S) REQUESTED *(Please refer to resource package for description of services)*

☐ URGENT (please explain):_____
***Mandatory to call:** Oncology (Palliative Physician On-Call: 705-523-7100 x1100) or Non-Oncology/Hospice (CHPCT: 705-586-2273)
Case discussed with:_____
☐ MD or NP Specialist Palliative Care Consultation: CHPCT / PSMC
If HSN discharging to home – indicate MRP in community for Palliative coverage (Name/Phone):_____
☐ Residential Hospice End-of-Life Bed (Prognosis 3 months or less): MMH
☐ Pediatric EOL Bed: **Pediatric Referral form completed**
☐ Residential Hospice Alternate Care Bed (Prognosis 3-12 months): MMH
☐ Grief and Bereavement Service: MMH Supportive Care Program
☐ Visiting Volunteer: MMH Visiting Hospice Services
☐ Home Care Services (ie. Nursing, PSW etc.): Ontario Health atHome

Additional Notes:

SECTION E – GOALS OF CARE

Goals of care discussed with referring provider:☐Yes ☐No Patient agreeable to palliative approach to care: ☐Yes ☐No
No Resuscitation Status (DNR): ☐Yes ☐No An in-home pronouncement is in place: ☐Yes ☐No
Preferred place of death: ☐ Home ☐ Hospice☐ Hospital Patient Requires Symptom Relief Kit:☐Yes (order required) ☐No

SECTION F – REFERRAL INFORMATION

Referring Provider (please print) | Organization | Phone

Name of individual completing form (if not referring Provider | Date(yyyy/mm/dd)

For MAID request please contact Ontario MAID Care Coordination Service: 1-866-286-4023
For HSN PCU Bed requests please call 705-675-4755

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SECTION G - ADDITIONAL INFORMATION

FOR USE BY HCCSS

Purpose: *to provide additional information related to the original referral form, allowing for updates or clarifications without altering the content provided by the referring provider / delegate.*

Please use this section to include any relevant details that were not part of the initial referral form (ie) follow up notes, treatment plan(s), upcoming appointments, additional notes from conversations with patient/family

Patient Name	Date of Birth	Health Card Number/ Version Code/ Expiry Date

Printed Name	Signature/Designation	Date(dd/mm/yyyy)