Referral Principles

- Completion of this referral is a request for an immediate admission to the Hospice Care Ottawa or to the Bruyère Palliative Care Unit. Referrals should only be submitted when an admission is required. Future or back- up referrals will not be accepted.
- Patients referred to Hospice Palliative Care are centrally triaged based on established criteria into the most appropriate care setting.
- Admission Criteria: CRT - Admission Criteria
- Submit completed referrals to fax 613-562-4226, or via encrypted and password-protected email to bruyereclinicaladmissions@bruyere.org

IMPORTANT:

- A copy of the medication administration record (MAR) and the physician's discharge summary **must** accompany the patient at time of transfer.
- Include any relevant attachments.
- * indicates a mandatory field.
- You will be contacted with the referral / triage decision.

I have informed the patient and/or the patient's substitute decision-maker about the purpose for the collection of the information in this application which will be used to assist in determining admission to the Hospice Care Ottawa or the Palliative Care program at Bruyère Continuing Care based on the needs of the patient, and that their consent can be withdrawn at any time by writing to the Privacy Officer of Bruyère Continuing Care (43 Bruyère Street, Ottawa, ON K1N 5C8).

☐ ***Yes, I have completed this task.****

Referral completed by*:
Tel.*:
Pager or cell phone:

Referral Information

Patient's Current Location*:	**Date of Referral Completion*:**
Unit Number:	**Contact Number:**
LHIN Home and Community Care Involvement ◯ **Yes** ◯ **No**	
Referring Physician (full name)*:	**Tel.*:**
	Pager*:
Family Physician (full name):	**Tel.:**
	Pager:

Patient Demographics

Surname*:	Given name*:
Sex*:	Date of birth* (dd/mm/yyyy):
Address*:	
City*:	Province*:
Postal Code*:	Home phone:
Preferred Language*:	Marital Status*:
Health Care Number*:	Version Code:
	Expiry Date:

Patient's Contact Information

First Contact*:	
Relationship*:	Tel.*:
Substitute Decision-Maker (personal care):	
Relationship:	Tel.:
Power of Attorney for Property:	
Relationship:	Tel.:

Reason for Referral

Select all that apply:

- ☐ End of Life Care - EOL (last days to weeks)
- ☐ Patient or family do not wish home death
- ☐ Symptom management and EOL care
- ☐ Symptom management with potential discharge
- ☐ Other (specify):

Medical Information

Note: See last page should additional space be required

Main Diagnosis:	
Date of Diagnosis *(month/year)*	
Summary of treatments (e.g., chemo, radiation, dialysis):	
Noteworthy complications of main diagnosis (i.e. spinal cord compression, delirium):	
Noteworthy Past Medical History:	
Weight *	_____ ◯ kg or ◯ lbs

Allergies:	
Infections requiring precautions?*	◯ YES ◯ NO
IF **YES**, specify: ☐ MRSA ☐ Active TB ☐ C-diff ☐ Outbreak unit ☐ CPE ☐ Shingles ☐ Other: Details of precautions in place:	
Does patient require the use of a negative pressure room? *	◯ YES ◯ NO
Use of cytotoxic Medications in last 72 hours? *	◯ YES ◯ NO
IF YES, provide name of medication and timeframe of usage:	

Psychosocial Situation

Select all that apply:

- ☐ Patient and/or family coping difficulties
- ☐ Patient lives alone
- ☐ Caregiver stress, illness
- ☐ Family tension
- ☐ Substance abuse
- ☐ Psychiatric issues
- ☐ Behavioral issues
- ☐ Social isolation
- ☐ History of reported violence (patient or family)

Please provide details:

Goals of Care and Advance Care Planning

Date and content of most recent goals of care discussion (example: preferred place of death, personal preferences, values, concerns/fears, religious/spiritual requirements/supports):

DNR: ◯ YES ◯ NO

IF YES, ☐ DNR discussed and confirmed with patient/SDM

(*please forward DNR documentation at time of transfer)

Patient Symptom and Needs Profile: Palliative Performance Scale (PPS)

* *Select one*

Check Condition	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
◯	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
◯	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
◯	80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
◯	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
◯	60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
◯	50%	Mainly Sit/Lie	Unable to do any work Significant disease	Considerable assistance required	Normal or reduced	Full or Confusion
◯	40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
◯	30%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
◯	20%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
◯	10%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
◯	0%	Death				

Has there been a recent change in PPS ? ◯ YES ◯ NO

IF **YES**, please provide additional details about the recent change:

Pain and Symptom

Is the patient currently delirious?* ◯ YES ◯ NO

IF **YES**, please provide additional details:

Does the patient have a history of delirium?* ◯ YES ◯ NO

IF **YES**, please provide additional details:

Does the patient wander?* ◯ YES ◯ NO

Does the patient have a diagnosis of dementia? * ◯ YES ◯ NO

Please check symptoms most currently active at this time and provide additional details.
(*For example; severity of symptom, length of time present, level of intensity, remedial efforts to date, etc*.)

Symptom	Details
☐ Confusion	
☐ Agitation	
☐ Pain (specify where)	
☐ Fatigue/Drowsy	
☐ Shortness of breath	
☐ Nausea	
☐ Depression	
☐ Poor appetite	
☐ Anxiety	
☐ Constipation	
☐ Psychological/ Spiritual	
☐ Social Stressors	
☐ Other (specify)	

Swallowing and Intake

Difficulty swallowing or chewing: ◯ YES ◯ NO

Current diet order:

Intake: ☐ Normal ☐ Reduced ☐ Sips Only ☐ NPO

Equipment & Intervention Needs

* ***All fields required***

IV in use: YES NO
IF **YES**, access: peripheral sub Q

Central line: YES NO
IF **YES**, Type:
Date of last flush:

PICC: YES NO
IF **YES**, type:
Number of lumens:

CADD pump: YES NO Epidural: YES NO Intrathecal: YES NO
Other:

Enteral feed YES NO
IF **YES**:

PEG PEJ NG	Bolus Continuous
Product used:	Volume per feed:
Hourly rate:	Frequency:

Flush: YES NO
IF **YES**, frequency:
Volume per flush:

Chest tubes: YES NO
Chest tube type:
- Pleurx or tunneled catheter
- Pigtail or small-bore catheter
- Large bore catheter
- Other:

Date of last drainage:
- Gravity
- Continuous suction at mmH_20
- Intermittent suction or drainage (details):

Abdominal Drain: YES NO
Abdominal drain type:
- Pleurx or tunneled catheter
- Pigtail or small-bore catheter
- Other:

Date of last drainage:
- Gravity
- Continuous suction at mmH_20
- Intermittent suction or drainage (details):

Type of mattress in use:

Supplemental Oxygen: YES NO
IF **YES**, LPM:
Via NP Mask Other:

BiPAP: YES NO Does patient have own machine and mask? YES NO
IF **YES**, Settings:
Frequency:

CPAP: ◯ YES ◯ NO

IF **YES**, Settings:

Frequency:

Does patient have own machine and mask? ☐ YES ☐ NO

Tracheostomy: ◯ YES ◯ NO

IF **YES**, ☐ Cuffed ☐ Uncuffed

Size and brand:

Is the patient suctioned: ☐ YES ☐ NO

IF **YES**, type:

Frequency:

Other equipment in place that is not listed:

Surgical wounds and/or other wounds: ◯ YES ◯ NO

IF YES, specify (use additional information section if required):

Wound site	Stage	Type of dressing in use

Elimination Device

Device	Supplies required	Date of last change
Colostomy: ☐ YES ☐ NO		
Ileostomy: ☐ YES ☐ NO		
Nephrostomy: ☐ YES ☐ NO		
Ileo-conduit: ☐ YES ☐ NO		

Additional information: