Regional Palliative Care Referral Form

Referrals can be sent via CRMS/Meditech/or faxed to:
Regional Palliative/End of Life Care Team
c/o April Anstey
Fax: 709-884-4274 Tel: 709-884-4268

Date: _____ Person Referring Patient: _____ Referral Contact No.: _____
Patient Full Name:_____ Male □ Female □
Mailing Address: _____ Telephone: _____
Date of Birth: Day_____ Month_____ Year_____
MCP #: _____

Estimated Prognosis: Less than one week □ Less than one month □ 1 to 3 months □ 3 to 6 months □
Is client aware of diagnosis & prognosis? Yes □ No □
Is client aware of AND in agreement with referral to Palliative Care? Yes □ No □
Does the client have a completed 'Do Not Resuscitate' Order? Yes □ No □ (If yes, please attach copy)
Does the client have an Advance Health Care Directive? Yes □ No □ (If yes, please attach copy)
Has there been discussion of treatment issues related to end of life care? Yes □ No □
Identify issues discussed: _____
_____

Primary Caregiver: _____ Relationship: _____
Address: _____ Telephone: _____

Family Physician Name: _____ Telephone: _____
Fax Number: _____
Client's Current Location: Home □ Hospital □ Long Term Care Facility □ Other □ _____

Reason for Referral (please check all that apply):
Pain Management □ Symptom Control □ Explain: _____
Future Care Planning □ Psychological/Social □
Caregiver/Family Distress □ Spiritual □ Grief/Bereavement □ **Date of Diagnosis**: _____

Primary Diagnosis & Summary of Progression of Disease:
_____
_____

Relevant History relative to reason for referral:
_____
_____
_____
_____

***PLEASE ATTACH CURRENT MEDICATIONS & RELEVANT TREATMENT HISTORY**

THE FOLLOWING MUST ALSO BE COMPLETED BY A PHYSICIAN/NURSE PRACTITIONER
IF PHYSICIAN SPECIALIST SERVICES ARE REQUIRED

Physician's Signature:	Name (Please Print):	Date:

FOR OFFICE USE ONLY:
Accepted: □ Pending: □ Denied: □ Reviewed by: _____ Date: _____
Explanation (Pending/Denied):