Mississauga Halton CCAC
Advanced Practice Nurse/Nurse Practitioner (APN/NP)
Palliative Care Referral Form

Please complete and fax to 905-855-8989

Patient Contact Information

Patient Surname:		Patient First Name:	
Date of Birth: (DD/MM/YY)		Gender:	☐ Male ☐ Female
Health Card Number & Version Code:		BRN (if known):	
Home Phone Number:			
Home Address:			

Patient Information/Physician Information

Primary Diagnosis:		Metastases (if cancer):	
Secondary Diagnosis:		MRP Identified:	☐ Yes ☐ No
MRP Name:		MRP Phone Number:	
Family Physician (FP):		FP Phone Number:	
Current PPS % *(see chart below)*:			
Prognosis:	☐ < 12 months ☐ < 6 months ☐ <3 months	☐ < 1 month ☐ Patient with Palliative Care needs regardless of prognosis or diagnosis	

Referral Information

<u>URGENCY</u>: 90-95% of patients to be seen within 5 business days or less

☐ 1 Severe symptoms; severe psychosocial distress or dysfunction
☐ 2 Moderate symptoms; moderate psychosocial difficulties
☐ 3 No or mild symptoms

<u>Reason for Referral</u>

☐ Complex and/or refractory pain and symptom management

☐ Complex and/or refractory psychosocial needs of patients and families

☐ Development of goals of care and/or end-of-life planning

☐ Other:

Please explain:

☐ Shared care with most responsible provider (MRP)

☐ Strategies to reduce repeated unnecessary ER visits or hospitalizations

☐ Complex hospital discharge or other transitions

<u>Referral Information Required</u>

Attach consultations and recent clinical notes (**Mandatory** for referrals outside of MH region)

Other clinicians/referrals made/involved:

Referring Clinician: Phone Number:

Completed by (print): Date (DD/MM/YY):

Designation: Phone Number: