Carefor® HEALTH & COMMUNITY SERVICES / SERVICES & SOINS DE SANTÉ COMMUNAUTAIRES

Hospice CORNWALL

Patient Name:_____

Carefor Hospice Cornwall Referral and Assessment Form

Patient Demographic

Surname:	Middle Name:		Given Name:
Gender: □ Male □Female □ L/G/B/T/Q	Date of Birth (dd/mm/yyyy):		Nickname:
Address:			Home Phone:
City:	Province:	Postal Code:	Email:
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Other:			
Mother-Tongue: □ French □ English □ Other:		Faith/Group:	
Language most comfortable communicating in: □ French □ English □ Other:			
Health Card #:	Version Code:		Expiry Date:

Patient's Contact Information

First Contact:		
Relationship:	Cell:	Tel:
Second Contact:		
Relationship:	Cell:	Tel:
Substitute Decision Maker/POA (personal care):		□ Jointly □ Severally
Relationship:	Cell:	Tel:
Address:		Postal Code:
Secondary Substitute Decision Maker/POA (Joint):		
Relationship:	Cell:	Tel:

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Address:		Postal Code:
Email:	Cell:	Tel:
Referring Physician/Primary Care Provider(NP):	Cell:	Tel:
Family Physician/Nurse Practitioner:	Cell:	Tel:
Pharmacy Name, (if community referral):	Tel:	Fax:

Referral Information

Patient's Current Location: □ Home □ Rest and Retirement Home □ LTCH
□ Hospital Hospital Name:_____ Room # _____

CCAC involvement: □ Yes □ No CCAC Care Coordinator: Ext:

LTC initiated : □ Yes □ No

Referral Completed by:

Reason for Referral

□ 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 (details):

Medical Information

Primary Diagnosis:

Secondary Diagnosis:

Date (Month & Year) of Diagnosis:

If Cancer, metastatic sites:

Summary of Treatments (chemo, radiation):

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Last Date of Treatment:
Noteworthy complications (i.e. spinal cord compression, superior vena cava syndrome, SIADH):
Noteworthy Past Medical History:
Infections: □ MRSA+ □ VRE+ □ C-diff □ Outbreak unit □ Other:
Allergies & Sensitivities:
FRI Screen: □ Positive □ Negative
Psychosocial Situation
□ Patient and/or family coping difficulties □ Patient lives alone □ Caregiver stress, illness
□ Family tension □ Substance abuse □ Psychiatric issues □ Behavioural issues □ Social issues
Goals of Care and Advanced Care Planning (*select all that apply*)
□ Patient/SDM/POA aware of diagnosis & prognosis
□ Patient/SDM/POA informed and consents to admission for Hospice services
□ DNR discussed and confirmed with Patient/SDM ** Patients require a DNR to be admitted to Cornwall Carefor Hospice.*
Would you be surprised if this patient was alive in 6-12 months? □ Yes □ No
Specific patient care needs:

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No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No drowsiness (Drowsiness=feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression=feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety=feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing=how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Date _____ Time _____	Completed by (check one): □ Patient □ Caregiver-assisted □ Family Caregiver □ Health care professional caregiver

Details:

Patient Name:_____

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

Symptoms: Edmonton Symptom Assessment Scale (ESAS)	
Can the patient complete the ESAS? □ Yes □ No	
If no what is the reason?	□ Patient too ill (PPS < 30%) □ Language barrier □ Cognitively impaired/delirious □ Other:

Swallowing & Intake	
Difficulty swallowing or chewing □ Yes □ No	Current diet :

Equipment Care Needs		
IV in Use: □ Yes □ No	Access: □ Peripheral □ Sub Q	
Central Line: □ Yes □ No	Type:	Date of last flush:
	Type:	Date of last flush:

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PICC: □ Yes □ No	Type:	Number lumens:
Cadd Pump: □ Yes □ No	Epidural: □ Yes □ No	Intrathecal: □ Yes □ No Other:

Elimination Device	Supplies Required	Date of last change
□ Colostomy		
□ Ileostomy		
□ Nephrostomy		
□ Ileal-conduit		
□ Foley Catheter		

Oxygen: □ Yes □ No	LPM: NP Mask Other:		
Tracheostomy: □ Yes □ No	Size and brand: □ Cuffed □ Uncuffed		
Is the patient suctioned? □ Yes □ No	Type:	Frequency:	
External feeding: □ Yes □ No	Route: PEG PEJ N/G Bolus Continuous		
Product used:	Volume per feed:	Hourly Rate:	Frequency:
Flush: □ Yes □ No	Frequency:	Volume per flush:	
Chest tubes: □ Yes □ No			

Wound Sites	**Stage**	**Type of dressing in use**
1)		
2)		
3)		
4)		

Recent Events Leading to Request for Admission to Hospice:

Patient Name:_____

Concerns of Family/Patient:
Signature of Assessor: / Date:

Patient Name: _____

Referral for Hospice Checklist

Please include the following with the referral package:

- □ Cornwall Carefor Hospice Referral Form
- □ Recent bloodwork
- □ Recent Diagnostic Imaging Reports
- □ The last 48 hours of progress notes
- □ Admission History and Physical

_____ _____

Signature Date