Hospice CORNWALL
Serving Cornwall & Area
Au service de Cornwall et des environs

1507 Second Street West, Cornwall, ON K6J 1J5
Tel: 613-938-2763 Fax: 613-938-7665

ADMISSION REFERRAL FROM HEALTH CARE PROVIDER

Surname _____ First Name _____

Date of Birth (D/M/Y) _____ Telephone # _____

Address _____ City _____

Province _____ Postal Code _____

Health Card Number _____

Marital Status: Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Other ◯

Anticipated Admission: Urgent ◯ Days ◯ Weeks ◯

Admission for: End of Life Care ◯ Symptom Management ◯ Respite ◯
Possible Future Admission ◯

Referred by: MD ◯ CCAC ◯ Agency ◯ Hospital ◯ Other ◯

CONTACTS

	Name	Relationship	Tel # (home)	Tel # (cell)
First contact				
Power of Attorney (Personal)				

CONTACTS

	Name	Telephone #	Fax #
Current Attending Physician			
Family Physician			
Other Physician			
CCAC Case Manager			

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Patient's Name: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Palliative Performance Scale (PPS 10% - 100%): _____

PATIENT CARE NEEDS

☐ Port-O-Cath ☐ Hickmann ☐ PICC Date of last flush _____

☐ Colostomy ☐ Nephrostomy ☐ Foley Catheter Date of last change _____

☐ SC Line: Date of last change _____ ☐ Oxygen _____ ☐ LPM _____

☐ Tracheostomy: Size _____ Brand _____ Isolation: ◯ Yes ◯ No Reason _____

☐ Enteral Feeding: Name of Supplement _____

☐ Dressing: Site 1. _____ Type _____

Site 2. _____ Type _____

Present Location of Patient: ◯ Home ◯ Hospital ◯ Retirement Home

Case Manager: _____ Telephone Number: _____

Extension: _____

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Patient's Name: _____

RELEVANT PAST MEDICAL HISTORY

EVENTS LEADING TO REQUEST FOR ADMISSION

PSYCHOSOCIAL INFORMATION

DNR STATUS HAS BEEN DISCUSSED AND CONFIRMED WITH PATIENT AND FAMILY.

◯ Yes ◯ No

Referral Made By: _____

Signature: _____

Date: _____