JOSEPH BRANT HOSPITAL

OUTPATIENT PALLIATIVE CARE CLINIC
REFERRAL RECORD

Phone: 905-632-3737 ext. 2108
Fax: 905-336-6492
Hours of Operation: Monday to Friday 8:00 a.m–4:00 p.m.

Patient Name: _____

Address: _____

_____

Telephone: _____

****LACK OF INFORMATION MAY DELAY APPOINTMENT SCHEDULING****

☐ NP CLINIC ☐ PALLIATIVE CLINIC

Date of referral (d/m/y): _____Referred by: _____

Family Physician: _____Contact Number: _____

Our clinic practices in a shared care model with family physicians. Please note we do not take over care. It is essential that the family doctor is aware of and consents to the referral.

☐ Attached letter faxed to family doctor

Diagnosis: _____ Prognosis: _____weeks/months/years

Palliative Performance Scale Level: _____% On Palliative home care?: ☐ YES ☐ NO

REASON FOR REFERRAL: (Domains of issues on reverse side)

☐ Pain Management
☐ Symptom Management
☐ Practical Issues (ADL'S etc.)
☐ Death Management Issues
☐ Social Issues (Relationships, Financial, Legal)
☐ Loss and Grief
☐ Spiritual Issues (Meaning, Faith/Religion)
☐ Psychological Issues (Coping, Family function, etc.)

CURRENT CONCERNS: _____

_____

_____

_____

_____

_____

ENCLOSED ARE MOST RECENT: ☐ Lab Work (CBC, LFT, renal function) ☐ Imaging ☐ Consult Notes

NEXT OF KIN: _____RELATIONSHIP: _____

PHONE NUMBER: _____

OTHER HEALTH PROBLEMS: _____

_____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: _____

SIGNATURE/STATUS: _____ Phone number**:** _____