

NON-MALIGNANT PALLIATIVE CARE CLINIC REFERRAL FORM

Please complete all information on the form and fax to (226) 330-0442 , along with any pertinent clinical notes or investigations not available on PowerChart/Clinical Connect	
DATE OF REFERRAL:	
PATIENT INFORMATION	REFERRING PHYSICIAN
Name:	Name:
Gender:	Specialty:
Date of Birth:	Billing #:
Address:	Phone #:
Phone #:	Fax #:
Health Card #:	Family Physician Name:
LHSC PIN#:	
<i>Alternate Contact Person</i>	Is this patient currently receiving services with the SWLHIN?:
Name:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Phone #:	

REFERRAL CRITERIA

Patients **MUST** meet the following. Please tick each box to indicate this patient meets these criteria.

<input type="checkbox"/>	Patient has at least one life-limiting non-malignant illness, or a degree of multi-morbidity that is cumulatively deemed to be life-limiting				
<input type="checkbox"/>	Patient is well enough to attend in-clinic visits <i>(If not, patient should be referred to Palliative Care Outreach Team through the SWLHIN)</i>				
<input type="checkbox"/>	Patient is aware of referral to Non-Malignant Palliative Care Clinic				
<input type="checkbox"/>	Patient has an estimated prognosis of one year or less Estimated Prognosis (please check appropriate box): <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Less than one month</td> <td style="width: 50%;"><input type="checkbox"/> Less than 6 months</td> </tr> <tr> <td><input type="checkbox"/> Less than 3 months</td> <td><input type="checkbox"/> Less than 1 year</td> </tr> </table>	<input type="checkbox"/> Less than one month	<input type="checkbox"/> Less than 6 months	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Less than 1 year
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<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Less than 1 year				

Patient has palliative needs identified by referring physician, including but not limited to: <ul style="list-style-type: none"> <input type="checkbox"/> Assistance with goals of care/advanced care planning <input type="checkbox"/> End-of-life planning <input type="checkbox"/> Pain and symptom management <i>(Please note we DO NOT see isolated chronic pain)</i>	Please indicate patient's current treatment plan. <i>(A desire for active medical management does NOT preclude a patient from being seen at our clinic).</i> <ul style="list-style-type: none"> <input type="checkbox"/> Full resuscitative measures <input type="checkbox"/> Active medical management without resuscitation <input type="checkbox"/> Supportive/comfort measures only
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Main Palliative Diagnoses:

Current Palliative Needs: