**Palliative Care Consult Referral Form Please Fax to: 905-827-2089**

|  |  |
| --- | --- |
| Date of Referral | Click here to enter a date. |

 **Health Care Provider (HCP) Making Referral - Contact Information**

|  |  |
| --- | --- |
| Name of HCP | Last Name, First Name Profession / Job Title: Choose an item Enter here for Other |
| Organization Name, Unit & Address | Click here to enter text.  |
| HCP Contact Information | Phone: Click here to enter #. Ext. Ext # Email: Email  |
| Alternate HCP’s Contact Information *if different from person filling this out* | Last Name, First Name Profession / Job Title: Choose an item Enter here for Other Phone: Click here to enter #. Ext. Ext # Email: Email  |

**Patient/Resident Information**

|  |
| --- |
| Patient/Resident Name: Last Name, First Name. Address same as above: Yes[ ]  No[ ]  OR: Enter Address  |
| Demographics | DOB: Day: 00 Month: 00 Year: 0000 Age: 00 |
| In your opinion, would you be surprised if the patient/resident dies in the next 12 months?  | Yes [ ]  No [ ]  |
| Is the patient/resident receiving a palliative approach to care? | Yes [ ]  No [ ]  |
| Palliative Performance Scale (PPS) |  Choose Score. |
| Diagnose(s)   | Click here to enter text.  |
| Allergies | Click here to enter text.  |
| Name of Most Responsible Physician (MRP) and or NP Involved | Click here to enter text.  |

**Is a Medication Administration Record (MAR) or Medication List Attached: Yes** [ ]  **No** [ ]  **OR fill out below:**

**Relevant Medication(s) for Symptom Control**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Route**  | **Times Given** |
| Click here to enter text. | Ent  | Ent | enter text. |
| Click here to enter text. | Ent | Ent | enter text. |
| Click here to enter text. | Ent | Ent | enter text. |
| Click here to enter text. | Ent | Ent | enter text. |
| Click here to enter text. | Ent | Ent | enter text. |
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| Click here to enter text.  | Ent | Ent | enter text. |
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| Click here to enter text. | Ent. | Ent | enter text. |

**SBAR Communication Tool**

|  |  |
| --- | --- |
| **S** | **SITUATION**The **complex problem/symptom** is: Click here to enter text  |
| **B** | **BACKGROUND**State the pertinent **medical history/any recent trauma:** Click here to enter text. Give a brief synopsis of the **treatment to date and effectiveness:** Click here to enter text.  |
| **A** |  **ASSESSMENT** **Cognitively Intact Cognitively Impaired**

|  |  |  |
| --- | --- | --- |
| **O**nset | Click here to enter text.  | **Assessment Tool Utilized:**PainAD: [ ]  Abbey: [ ]  PACSLAC: [ ]  Other: Click here to enter text. Result/Findings of Assessment: Click here to enter text. Is DOS being utilized?Yes [ ]  No [ ]  |
| **P**recipitating &Alleviating Factors | Click here to enter text.  |
| **Q**uality of Pain | Click here to enter text.  |
| **R**egion & Radiation | Click here to enter text.  |
| **S**everity | Click here to enter text.  |
| **T**iming | Click here to enter text.  |
| **U** “How is the pain  affecting you?” | Click here to enter text.  |
| **V**alues –What is the acceptable level  for this symptom? | Click here to enter text.  |

 |
| **R** | **RECOMMENDATIONS**What would your suggestions be? Click here to enter text. Results of relevant lab tests and imaging (X-Rays, CT, MRI etc.) & please include dates completed: Click here to enter text.  |

**Any other thoughts/concerns**:

Click here to enter text.

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