**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. |
| 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. |
| Click here to enter text. | Ent | Ent | enter text. |
| 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.

**Please Fax to: 905-827-2089**