Eastern Health
Palliative Care Program

Referral Form

Palliative Services/ Symptom Management

CL1530 1151 10 2013

Name:

HCN:

Date of Birth:

Please fax completed form to 709-777-8970. Incomplete forms will be returned and may cause a delay in access to services.

Patients we see:
Life-limiting illness or condition
On active treatment for symptom management, and/or with high symptom load, or finished active treatment
We provide:
Suggestions regarding symptom management of basic symptoms
Collaboration in managing complex symptom management
End of life care and/or limited symptom management in our PCU
Key Question: If the answer to the question "Would you be surprised if this patient was deceased in less than 1 year?" is *no*, then this is a patient who is appropriate for referral.

Referring Physician/NP: _____ Date of Referral: _____DD/MONTH/YYYY_____

Patient Contact: Location: _____Telephone:_____

Service(s) Requested: ☐ Symptom Management ☐ Pre-approval for Palliative Care Unit

*We request **early** referral of patients with life-limiting illness and symptom burden.*

Primary Diagnosis: _____

_____

_____

(May be cancer or any life-limiting illness)

Individual Aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No

Family Aware of:Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No

Individual Is Aware of Consult: ☐ Yes ☐ No

Anticipated Prognosis: ☐ Less than 1 month ☐ Less than 3 months ☐ Less than 6 months ☐ Less than 12 months ☐ Uncertain

Please specify the following:

Stage of Disease: _____

Primary Symptom: _____

_____

Symptom Intensity: ☐ Mild (1-3/10) ☐ Moderate (4-7/10) ☐ Severe (8-10/10)

Current treatment goals/plan: ☐ Curative ☐ Palliation

Is the patient on chemotherapy: ☐ Yes ☐ No Is the patient on radiation: ☐ Yes ☐ No

Other pertinent treatments: _____

_____

Code Status: ☐ No Code Blue ☐ Full Code ☐ Not discussed/Other

Physician/Nurse Practitioner Name:_____Date:_____DD/MONTH/YYYY_____

Physician/Nurse Practitioner Signature:_____