Palliative Care Community Team

Name _____ DOB _____ Gender ☐ M ☐ F ☐:_____
MM/DD/YYYY
Address _____ Phone _____-_____-_____

Email: _____ Health Card# _____

☐ Kawartha Lakes	☐ Haliburton	☐Scarborough	☐ Peterborough	☐ Northumberland	☐ Durham
Community Care City of Kawartha Lakes Tel: 705.879.4123 **Fax:** 705.880.0531	*Haliburton Highlands Health Services* Tel: 705.457.2941 Extension 2930 **Fax:** 705.457.5077	*Scarborough Centre for Health Communities* Tel: 416.847.4111 **Fax:** 416.261.0782	*Hospice Peterborough* Tel: 705.742.4042 **Fax:** 705.742.0064	*Community Care Northumberland* TF:1. 855.473.8875 **Fax:** 905.372.3898	*VON Canada – Ontario Region* Tel: 905.240.4522 TF: 1.877.668.9414 **Fax:** 905.240.4533

*NOTE: *Referrals Reviewed Monday-Thursday: 9am - 4pm; Friday: 9am – 1pm*

Service Type Requested

☐ Palliative Care Community Team ☐ Grief & Bereavement ☐ Caregiver Support ☐ Hospice Volunteer
☐ Palliative Pain & Symptom Mgmt Consultation/Clinic ☐ Hospice Bed ☐ Other:

Referring Individual

Name: _____ Tel _____-_____-_____

Agency/Role: Fax - -

Urgency
☐<24 hours
☐1-2 Business Days
☐<1 Week
☐1 Week
☐1-2 Weeks
☐>2 Weeks

PPS *(see reverse, if applic.)*
☐100% ☐ 50%
☐90% ☐ 40%
☐80% ☐ 30%
☐70% ☐ 20%
☐60% ☐ 10%

Client Consent to Referral ☐ Yes ☐ No

Consent Given By: _____

Current Services in Place:
☐ CCAC ☐ Family Health Team ☐ Hospital
☐ Community Health Centre ☐ Hospice
☐ General Practitioner ☐ Oncologist
☐ Counsellor/therapist/psychol./psychiatry
☐ Other:

Primary Health Care Provider _____
_____
Telephone (_____)_____-_____

Substitute Decision Maker Information:

Name_____
Relationship to Client_____
Telephone (_____)_____-_____
Call and speak with patient directly? ☐ Yes ☐No
Address:

Same as client ☐

Comments:

Reason for Referral

Palliative Care

Date of Diagnosis _____ /_____ /_____ Prognosis _____ _____
MM DD YYYY Months Weeks

Primary Diagnosis (& co-morbidities):

Is client aware of prognosis/diagnosis? ☐Yes ☐No
Is family aware of prognosis/diagnosis? ☐Yes ☐No
Resuscitation Status: ☐ DNR Discussed: ☐Yes ☐No Signed: ☐Yes ☐No

Grief / Bereavement

Name of Person Who Died:_____ Date of Death: _____
Nature of Death: _____ Relationship of Deceased to client: _____
Comments:

Caregiver Support

Name of Person caring for: _____ Relationship to this person: _____
Medical/psych. condition of the person they are caring for _____
☐ Distress ☐ Exhaustion ☐ Overwhelm ☐Requires respite ☐ Difficulty coping ☐ Other: _____
Comments:

Additional Comments:

* Please attach all supporting documents, tests results, or investigations with this referral *

Palliative Performance Scale (PPSv2)
version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Converting Clinical Frailty Scale (CFS) and Palliative Performance Scale (PPS)	
Clinical Frailty Scale	Palliative Performance Scale
3-4	70-90
5	60
6	40-50
7	10-30
Note: *CFS 1 and 2 and PPS 100 are not included in this conversion chart because data were unavailable for those scores.*	

<u>Note:</u> Sending in this referral form does <u>not</u> automatically mean the patient has been accepted for service.

<u>Office Use Only</u>

Date of Referral Received: _____ /_____ / _____
Date of First Contact: _____ /_____ /_____
Entered Into Database: _____ /_____ / _____
MM DD YYYY

Staff Initials: _____

Ontario
Central East Local Health Integration Network