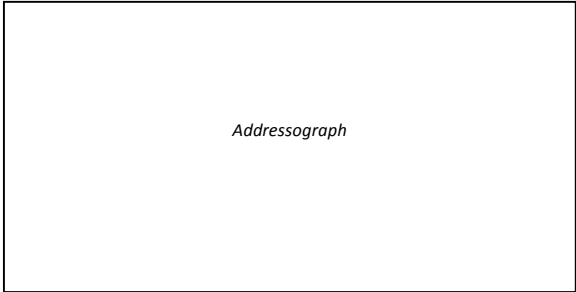


Ed's House Northumberland Hospice Care Centre

Bed Referral Form

TO ALL PALLIATIVE CARE PROVIDERS



Addressograph

ONLY if client is an existing Northumberland Palliative Care Community Team (PCCT) client, with Hospice Clinical Navigation supports in place, complete box below. Otherwise complete entire document (if unsure please call Hospice Services at 1-855-473-8875)

- Consult note from EMR (including diagnosis, current symptoms, and any concerns)
- Current Medication List
- Completed *Palliative Care Order Set*
- Complete page 2 only

Home Address: _____ **Apt:** _____ **Entry Code:** _____ **Postal Code:** _____

Home phone number: _____ **Alternate number:** _____

Date of birth: (DD/MM/YY): _____ **Gender:** _____

Health card number: _____ **Version code:** _____

Primary language(s): _____ **Translator (name/phone#):** _____

Current location: Home Residential Hospice Other: _____

Hospital _____ Anticipated hospital discharge date: _____

Primary Palliative Diagnosis: _____

Other relevant diagnosis/symptoms: _____

Substitute Decision Maker/ POA: _____ **Contact #:** _____

If cancer diagnosis: ongoing treatment: Yes No Describe: _____

Individual aware of: Diagnosis: Yes No Prognosis: Yes No Does not wish to know: Yes No

Family aware of: Diagnosis: Yes No Prognosis: Yes No Does not wish to know: Yes No

Infection Control: MRSA/VRE (+) C-DIFF (+) Other (*specify precaution*): _____

Allergies: Yes, specify: _____ No

Pharmacy (name and number) If Known: _____

Please include most recent medication list (Include complementary alternative and over-the-counter medications)

Special care needs: (please check all that apply) SC Infusion pump(s) P.I.C.C. line(s) Porta Cath

Tracheostomy Thoracentesis Paracentesis

Drains/Catheter (specify): _____

Oxygen: rate: _____

Wound care (specify): _____

Therapeutic surface (specify): _____

Other needs: _____

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Bed Referral Form

Individual's First & Last Name:

Any additional information: Details of social situation, including any needs/concerns of the family:

Individual Completing Form: _____ Tel: _____

(Referring) Physician: _____ Tel: _____

Primary Health Care Provider: _____

CPSO#: _____ Telephone Number: _____

****Primary Health Care Provider must have 24-hour coverage by self or buddy system****

I am interested in continuing to provide palliative care to my client, but need help with 24-hr coverage

MRP Daytime Phone: _____

MRP Afterhours Phone: _____

Date of Referral: (DD/MM/YY): _____

Please fax Completed Form to Ed's House Northumberland Hospice Care Centre at 289-252-0676