the hospice of Windsor and Essex County Inc.

HOSPICE
PALLIATIVE CARE PHYSICIAN REFERRAL

Referrals Received M-F / 9-5
Referrals sent after 5PM will be processed the next business day.

Date of Referral: _____

Name: _____ OHIP #: _____ VC: _____

Home Address: _____

Telephone: _____ Date of Birth: _____ (dd/mm/yy)

Alternate Contact Name: _____ Phone: _____ Relation: _____

Patient Location: ☐ Home ☐ WRH-M ☐ WRH-O ☐ HDGH ☐ ESHC ☐ Other ☐ Lives Alone ☐ Young children in home

Palliative Medicine Program-Physician/NP Referred Services only:
☐ Malignant pain and symptom management and end of life care – prognosis is less than 6 months
☐ Non- malignant end of life care – prognosis less than 3 months
☐ Palliative consult only (referring physician/NP to remain MRP for palliative care needs)

To help us prioritize the referral, please indicate the following:

Diagnosis:

Symptoms:

Prognosis: ☐ Weeks ☐ Less than 3 months ☐ Less than 6 months ☐ Other

Priority: ☐ Routine ☐ Urgent (usually within 3 business day) **The suggested priority is not a guarantee for a visit. It facilitates the Intake team to prioritize new referrals*

PPS: ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% **See Reverse for PPS Chart*

For URGENT referrals (any referral being requested other than ROUTINE):
- Call to speak to the Hospice Intake Team at 519-974-7100 ext. 2254
- Referrals are triaged at the time of receipt. Urgent faxes will NOT be accepted without telephone contact.

COMMUNITY PALLIATIVE CARE REFERRALS DO NOT REPLACE PRIMARY CARE RESPONSIBILITIES. OUR PROGRAM DOES NOT ACCEPT REFERRALS FOR CHRONIC PAIN.

Individual aware of: ☐ Referral ☐ Diagnosis ☐ Prognosis ☐ Does not wish to know (documented)

Family aware of: ☐ Referral ☐ Diagnosis ☐ Prognosis ☐ Does not wish to know (documented)

Is Home and Community Care involved? ☐ Yes ☐ No

Have Goals of Care been discussed with patient and/or family? ☐ Yes ☐ No

Does patient have a DNR-C form completed? ☐ Yes ☐ No

Goals and expectations, including patient's and family's understanding of reason for referral:

_____

_____

Patient last seen: _____ Referring physician/NP: _____

Billing #: _____ Signature: _____

PLEASE NOTE: Only physicians/NPs can refer to the palliative medicine program.

****Please include most recent investigations and physician notes.****

PLEASE FAX COMPLETED REFERRAL TO: The Hospice of Windsor and Essex County Inc.,
6038 Empress Street, Windsor, Ontario N8T 1B5 Fax: (519) 974-7672 Phone: (519) 974-7100

Palliative Performance Scale (PPSv2)

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	-	-	-	-