Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

Outpatient Non-Oncology Palliative Care Referral

Please select clinic location:	Referral Source:	**Please complete all fields and sign the form.**
☐ Oakville Trafalgar Memorial Hospital, 3001 Hospital Gate, Oakville, ON L6M 0L8	❒ In-Patient	**Missing or incomplete information will delay processing of referral.**
☐ Milton District Hospital, 725 Bronte Street South, Milton, ON L9T 9K1	❒ Out-Patient	
☐ Georgetown Hospital, 1 Princess Anne Drive, Georgetown, ON L7G 2B8		
Phone: 905-845-2571 ext 3239 **Fax: 905-815-5109**		

Personal Information

Name of Patient:		Gender: ❒ Male ❒ Female
Health Card Number:		Date of Birth:
Address:		
Phone Number:		Marital Status:
Person to Contact / Relationship to Patient (mandatory)	**Phone Number:**	Has the patient been informed about the referral? ❒ Yes ❒ No
Living Arrangements: ❒ Alone ❒ Spouse/Partner ❒ Family Is CCAC Involved? ❒ Yes ❒ No	Language: ____ Do you require Halton Healthcare to arrange interpreter services on your behalf? ❒ Yes ❒ No	

Referral Information

Referral Source: ❒ Physician Office ❒ ER ❒ CCAC ❒ Inpatient ❒ Other: ____

Referring Physician:	Phone:	Fax:
Referring Physician Signature:	Date of Referral:	Billing Number:
Name of Family Doctor:	Phone:	Fax:

Main Concerns: Please note – in order for referral to be processed in a timely manner, all information must be completed.

When to Refer:

- ❒ Heart failure
- ❒ Pulmonary disease
- ❒ End-stage renal disease
- ❒ Advanced liver disease
- ❒ Neurologic disorder (including stroke)
- ❒ Other (specify):

Criteria:

- ❒ Complex symptoms
- ❒ Progressive deterioration in functional status or rapid progression of illness over several months
- ❒ Prognosis < 1 year

Patients Who Do Not Meet Referral Criteria Include:

- ❒ Patients with chronic, stable disease and anticipated life expectancy > 1 year
- ❒ Patients with chronic pain problems not associated with a progressive terminal condition

Urgency Of Referral	
	❒ Routine Assessment: ____
	❒ Urgent Reason: ____

History

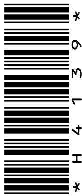
Past Medical History: ____

Specialists involved in care: ____

Medications: ____

Infection Control: Has the patient ever had any of the following infections (check all that apply)?

❒ MRSA ❒ VRE ❒ C. Difficile ❒ TB ❒ ESBL



Please Fax All Relevant Consult Notes, Recent Lab Work and Diagnostic Test Results To 905-815-5109