Central Intake: Oakville Community Palliative Care Physicians Referral

INCLUSION CRITERIA: ☐**PPS ≤50%** ☐ **LIVES IN OAKVILLE AREA**

Referring Provider (or Family Physician) agrees to remain MRP until patient is seen & accepted by CPCP
Referring provider agrees to resume MRP care if patient improves & no longer meets inclusion criteria
If CPCP accepts patient, all Physicians agree to stop billing G512

☐ CONSULT ONLY or ☐ CONSULT AND ASSUME MRP (if appropriate)

IF CPCP DECLINES PATIENT, REFERRING PROVIDER & PATIENT CONSENT FOR THE 'CPCP CENTRAL INTAKE TEAM' TO FORWARD THIS REFERRAL TO HALTON HEALTHCARE'S OUTPATIENT PALLIATIVE CARE CLINICS ☐

PATIENT DEMOGRAPHICS		
Patient Name:		DOB:
HCN:	VC:	Gender:
Address:		
Phone Number:	Who to contact with appointment: ☐ Patient ☐ Alternate Contact	
Alternate Contact Name:	Phone:	Relationship:
Language:	Translation Required? ☐No ☐Yes	
Current Location: ☐**Home**: ☐Alone ☐ Partner ☐Family	☐**Hospital**: Anticipated D/C Date:	
Ontario Health at Home (OH atHome) supports in place: ☐No (see below) ☐Yes: ☐PSW ☐Nursing ☐NP **Please complete an OH atHome Palliative Care Referral if they are not currently involved**		

MEDICAL INFORMATION	
Palliative Care Diagnosis:	Date of Diagnosis:
Other Medical History: Allergies: ☐ MRSA/VRE/ESBL	
Current Symptoms/Concerns:	
DNR: ☐YES ☐NO Patient aware of Diagnosis, Prognosis and Referral to Palliative Care **(REQUIRED)** ☐Yes	
Patient aware of Diagnosis, Prognosis and Referral to Palliative Care **(REQUIRED)** ☐Yes	
Palliative Performance Scale (PPS): Details:	

PROGNOSIS: ☐LESS THAN 2 WEEKS* ☐ 2 WEEKS-1 MONTH ☐< 3 MONTHS ☐< 6 MONTHS ☐< 12 MONTHS

*If very poor prognosis requiring urgent assessment – please page Milton Community Palliative Care Physician On-Call

****PATIENTS WILL BE CONTACTED WITHIN 1 WEEK OF REFERRAL ACCEPTANCE - THIS IS NOT AN EMERGENT CONSULT SERVICE****

FAMILY MD INFORMATION		
Name:	Phone:	Fax:
Family MD has been contacted, does **NOT** provide palliative care & is aware of the referral **(REQUIRED)** ☐ **YES**		
REFERRAL SOURCE		
Name:	MD/NP Billing Number **(REQUIRED)**:	
Phone (*Backline/Cell Preferred*):	Fax:	
Signature:	Date of Referral:	

ADDITIONAL INFORMATION ATTACHED (REQUIRED):

☐ **Medication and Dosages** ☐ **Labs and Imaging** ☐ **Consultations/ Recent Clinical Notes**

Central Intake Phone No. 905-855-9090 ext.5749
PLEASE FAX REFERRAL FORM AND ALL ACCOMPANYING DOCUMENTATION TO FAX No. 905-338-4434

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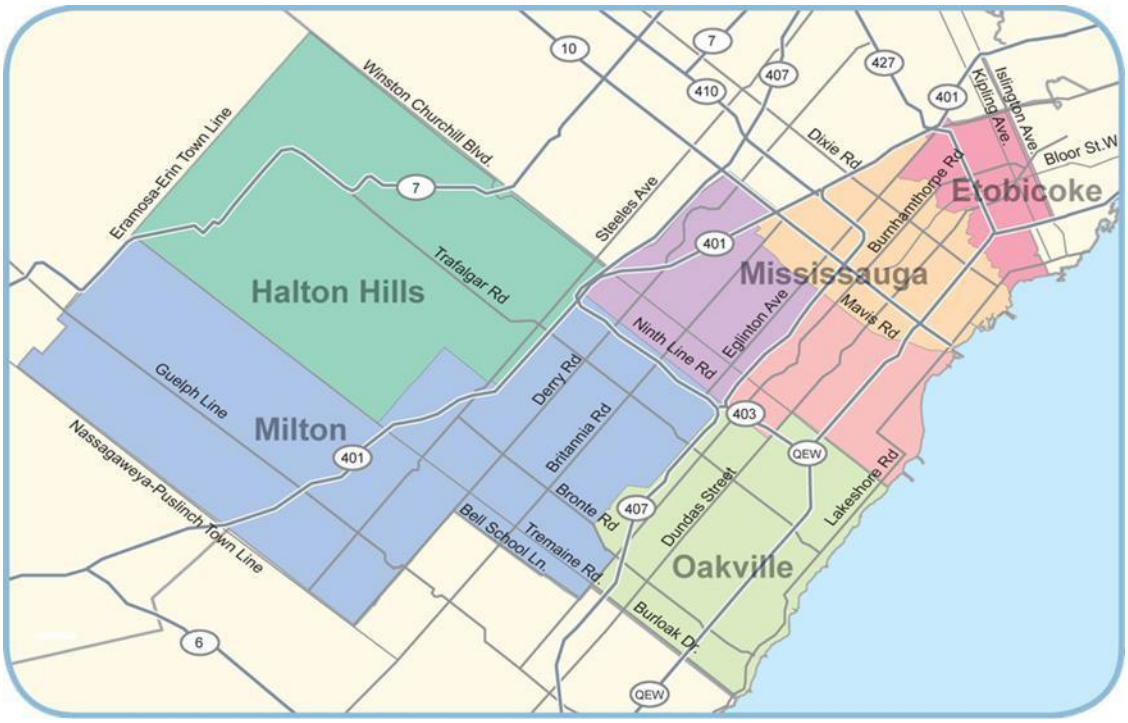

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Consciousness Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/housework 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 Bedbound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	----	---	---	---

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