HOSPICE RENFREW
CARE COMFORT COMPASSION

Connecting you with care
CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires

ADMISSION REFERRAL TO HOSPICE RENFREW

Please FAX completed form to : 613-432-3618

Admission request:

- ☐ Immediate
- ☐ Future
- ☐ Pain and symptom management

Referral Principles

-Completion of this referral is a request for an immediate admission to the Hospice Renfrew. Future or back-up referrals will be accepted.
-Patients referred to Hospice Renfrew are triaged based on established criteria into the most appropriate care setting. To ensure sufficient and accurate information is available as part of the referral package, the expectation is referred patients will have had an assessment by one of the following partners:

- Palliative Pain and Symptom Management Consultation Service
- Palliative care consultation teams at the Montfort, the Queensway-Carleton and the Ottawa Hospital
- Champlain Hospice Palliative Community Network community palliative care physicians

Please ensure a copy of the consult note is included in the referral package ☐ ***Yes, I have completed this task.***

I have informed the patient and/or the patient's substitute decision maker about the purpose for the collection of the information in this application which will be used to assist in determining admission to Hospice Renfrew based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Resident Care Manager at Hospice Renfrew (459 Albert Street, Renfrew, Ontario, K7V 1V8).

☐ ***Yes, I have completed this task.*** **Referral Completed by:**
Telephone:
Pager or Cell Phone:

Patient Demographics

Given name: _____Surname: _____

Sex: ☐ Male ☐ Female Date of birth (dd/mm/yyyy):_____ Home Phone: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other: _____

Preferred language: ☐ French ☐ English ☐ Other: _____

Health Card #:: _____ Version Code: _____ Expiry Date: _____

Reason for Referral

☐ End of Life Care - EOL (last days to weeks) ☐ Patient or family do not wish home death ☐ Symptom management and EOL care

☐ Symptom management with potential discharge ☐ Other (details) _____

Hospice Renfrew Services

Acute Palliative Pain and Symptom Management or Respite Admission (depending on bed availability) : Short Stay & Symptom Control	**For the very end of life: last days or weeks of life**
-Patients have a non-curable, progressive, life threatening disease -Require daily symptom mgmt. by specialist physician and team -Presence of persistent pain or other complex/difficult symptom, -ESAS ≥ 4/10 -PPS not a criteria	-Patients have non-curable, progressive life threatening disease with a prognosis of less than 3 months -Patients are not on curative therapy -PPS equal or less than 40% -DNR order in place -Valid OHIP number - Resident aware that hospice does not provide Medical Assistance in Dying

Discharge Criteria

Patients who no longer meet the admission criteria will be considered for discharge when:
-The intensity and clinical expertise of the program is no longer required
-The patient's functional status stabilizes or improves to such a degree that life expectancy exceeds just a few days or weeks.
- They and their families express the wish to return home
- Their care needs can be met at home or elsewhere
- They require a level of pain and symptom management more complex than that available at the Hospice.

Referral Information

Patient's Current Location: _____ Date of Referral Completion: _____

CCAC involvement: ☐ Yes ☐ No CCAC Case Manager: _____ Pager/Cell: _____

Referral Completed by: _____ Tel. _____ Pager: _____

Pharmacy in the Community: _____

Patient's Contact Information

First Contact: _____ Relationship: _____ Tel. _____

Substitute Decision Maker (personal care) _____ Relationship: _____ Tel. _____

Power of Attorney for Property _____ Relationship: _____ Tel. _____

Attending Physician (full name) _____ Tel. _____ Pager: _____

Referring Physician (full name)_____ Tel. _____ Pager: _____

Family Physician (full name) _____ Tel. _____ Pager: _____

Medical information

Main Diagnosis: _____

- Date of diagnosis (Month/year) _____
- If cancer, metastatic sites _____
- Summary of treatments (chemo, radiation, dialysis) _____

  _____
- Noteworthy complications (i.e. spinal cord compression) _____

  _____

Other Concurrent Illnesses _____

_____

_____

Noteworthy Past Medical History: _____

_____

_____

Allergies _____

Infections: ☐ Yes ☐ No
☐ MRSA+ ☐ VRE+ ☐ C-diff ☐ Outbreak unit ☐ Other _____
Details of precautions in place _____

- ✓ **A medical discharge summary must accompany the patient at the time of admission**
- ✓ **It is imperative to include a copy of the Medication Administration Record (MAR),**
- ✓ **5 days of progress notes and the medical admission history and physical with the application.**
- ✓ **Also, please ensure the MAR and previous 5 days of progress notes accompany the patient at time of admission.**
- ✓ **Reference Source must initiate CCAC referral prior to admission to Hospice Renfrew**
- ✓ **When coming from TOH/QCH or other site that has palliative care consultations – a consultation notes must be included.**

Psychosocial Situation

☐ Patient and/or family coping difficulties ☐ Patient lives alone ☐ Caregiver stress, illness ☐ Family tension

☐ Substance abuse ☐Psychiatric issues ☐ Behavioural issues ☐ Social isolation

Comments:

Goals of Care and Advance Care Planning (Do Not Resuscitate and Medical Assistance in Dying) (select all that apply)

- SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

Describe Goals of Care: _____

DNR: ☐ Yes ☐ No
If no please explain:

☐ Discussion has not occurred
☐ Patient request full code
☐ Full code is appropriate

If yes, please select:
☐ DNR Discussed and Confirmed with Patient/SDM

Advanced Care Directives:
☐ Yes ☐ No ☐ Not Sure

Date of most recent discussion (dd/mm/yyyy): _____
***Patients will be required to sign admission agreement and specific form acknowledging that Hospice Renfrew does not provide CPR**

- SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

Hospice Renfrew does not permit the provision of Medical Assistance in Dying ("MAID") or euthanasia by its staff within its premises. A request for MAID will not be carried out within the Hospice and makes the resident ineligible for end-of-life admission or if already residing in Hospice, arrangements will be made to transfer the resident to an appropriate facility/location offering MAID.
MAID Discussion
☐ Discussion has not occurred
☐ Patient requests MAID

If yes, please select:
☐ MAID Discussed and Confirmed with Patient/SDM

Date of most recent discussion (dd/mm/yyyy): _____
***Patients will be required to sign admission agreement and specific form acknowledging that Hospice Renfrew does not provide MAID**

Family Physician and Palliative Care Consultation Team Contact

Has the referring professional contacted the patient's family physician to provide follow-up medical care at the Hospice? ☐ Yes details_____ ☐ No

Has the referring professional contacted a Palliative Care Consult Team? ☐ Yes ☐ No
If yes, I have attached the consult summary ☐ Yes
**Please note that contact from physician to physician may be preferred for admission approval.

Patient Symptom and Needs Profile: Palliative Performance Scale (PPS)

Check √ Condition	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 Significant 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 Significant disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
	20%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
	10%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
	0%	Death				

Symptoms: Edmonton Symptom Assessment Scale (ESAS)

Can the patient complete the ESAS? ☐ yes ☐ no Date Completed: _____

If no, what is the reason? ☐ Patient too ill (PPS < 30%) ☐ Language barrier ☐ Cognitively impaired/Delirious

☐ Other: _____

ESAS Scores (please indicate score on the scale of 0 to 10. 0 indicates symptom is absent, while 10 is the highest severity of the problem).

Pain _____ Fatigue _____ Nausea _____ Depression _____ Drowsy _____ Appetite _____

Feeling of wellbeing _____ Shortness of breath _____ Other problem _____ details _____

Swallowing & Intake

Difficulty swallowing or chewing ☐ yes ☐ no Current diet order: _____

Intake: ☐ Normal ☐ Reduced ☐Sips only ☐ NPO

Equipment Care Needs

IV in Use: ☐ Yes ☐ No Access: ☐ Peripheral ☐ Sub Q

Central Line ☐ Yes ☐ No Type:_____ Date of last flush:_____

PICC ☐ Yes ☐ No Type: _____ Number lumens: _____

CADD Pump ☐ Yes ☐ No Epidural ☐ Yes ☐ No Intrathecal ☐ Yes ☐ No ☐ Other _____

Elimination:	**Last Bowel Movement (Date/Time/Quantity) :** **Last Void (Date/Time/Quantity):** **Foley Catheter:** ☐ Yes ☐ No Size/type: _____ Date inserted: _____

Elimination Device	Supplies required	Date of last change
☐ Colostomy		
☐ Ileostomy		
☐Nephrostomy		
☐ Ileo-conduit		

Supplemental Oxygen ☐ Yes ☐ No LPM _____ ☐ NP ☐ Mask Other _____

BiPAP: ☐Yes ☐No CPAP: ☐Yes ☐No Settings: _____ Frequency: _____ Does patient own mask? ☐Yes ☐No

Tracheostomy: ☐Yes ☐No Size and brand: _____ ☐ Cuffed ☐ Uncuffed

Is the patient suctioned? ☐ Yes ☐ No Type: _____ Frequency: _____

Enteral feeding: ☐ Yes ☐ No Route: ☐ PEG ☐ PEJ ☐ N/G Bolus☐ Continuous☐

Product Used: _____ Volume per feed: _____ Hourly Rate:_____ Frequency: _____

Flush ☐Yes ☐No Frequency: _____ Volume per Flush: _____

Chest tubes: ☐Yes ☐No ☐ Gravity ☐ PleurX ☐ Continuous ☐ Suction: _____ ☐ Intermittent _____ mmH_20

Date of last drainage: _____ Type of mattress in use: _____

Wound sites	Stage	Type of dressing in use