LONG TERM CARE REFERRAL FORM TO HPC TEAMS

FAX TO: 905-830-5978

Date of Referral: (dd/mm/yyyy) / / Urgency: □ 1-2 days □ within 1 week □ 1-2 weeks

Resident Name: (First) □ □ □ □ (Last) □ □ □ □
DOB: (dd/mm/yyyy) / / Gender: □ Female □ Male
Health Card #: □ □ □ □ Version Code: □ □ □ □

Long Term Care Home:
Address: □ □ □ □ City: □ □ □ □ Postal Code: □ □ □ □
Room #: □ □ □ □ Phone #: □ □ □ □

Phone #: □ □ □ □

Date of Admission to Nursing Home:

Primary Contact Person Name/Relationship: □ □ □ □ Phone #: □ □ □ □
Primary Care Physician Name: □ □ □ □ Phone #: □ □ □ □

REASON FOR REFERRAL:
□ Pain and Symptom Management Consultation

□ Other - please specify:

Is DNR Signed: □ Yes □ No □ Goals of Care:

PRIMARY DIAGNOSIS:
Cancer Metastases (check all that are known): □ Bone □ Brain □ Liver □ Lung
□ Other (specify):

Psychosocial History:


Current Medications:


PRESENTING SYMPTOMS (ESAS Scores): (rate symptoms: 0=no symptom, 10=worst symptom)

Pain: □ /10  Tiredness: □ /10  Nausea: □ /10  Depression: □ /10  SOB: □ /10
Anxiety: □ /10  Drowsiness: □ /10  Appetite: □ /10  Wellbeing: □ /10  Other: □ /10

Palliative Performance Scale (PPS)  □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

REFERRAL SOURCE:
Referring Name: □ □ □ □ Signature: □ □ □ □

Date: (dd/mm/yyyy) / / Phone #: □ □ □ □ Fax #: □ □ □ □
Form completed by: □ □ □ □ Phone #: □ □ □ □

PLEASE ATTACH: □ Recent Consultation Notes □ Current Medications □ Other Relevant Information

AD-HPC-28
### AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

**FAX TO:** 905-830-5978

I hereby authorize

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To release to

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<th>Hospice Palliative Care Teams for Central LHIN</th>
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<th>Stronach Regional Cancer Centre, 596 Davis Drive, Box 22, Newmarket, ON L3Y 2P9</th>
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Relating to

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<th>Name of Client</th>
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**Relevant Confidential Information, specifically,**

1. 

2. 

3. 

To be used for the following specific purpose(s):

1. 

   *Must be clearly stated*

2. 

Signature: ________________________________  Please Print Name

**Relationship to Client:**

- [ ] Self
- [ ] Parent
- [ ] Guardian
- [ ] Power of Attorney *
- [ ] Substitute Decision Maker
- [ ] Legally Appointed Designate *
- [ ] Other (please specify)

*If you are the Power of Attorney or Legally Appointed Designate, please provide a copy of the document to support your status.

Signature of Witness: ________________________________  Please Print Name

Date (dd/mm/yyyy): ________________________________

This release expires 90 (ninety) days from date signed.