



Palliative Care Program Application for Registration

Complete all sections of this form and forward to:
(Incomplete forms may delay processing.)

Addressograph	Date:	
	Person Referring Patient:	
	Source of Referring Agency:	
	Telephone:	

I D E N T I F I C A T I O N	Full Name:		Male: <input type="checkbox"/>	Female: <input type="checkbox"/>	
	Address:		Telephone:		
	Date of Birth <small>Day Month Year</small>		MHSC Family Number:	PHIN Number:	
	Next of Kin Name:		Relationship:		
	Address:		Telephone:		
	Primary Physician or Nurse Practitioner Name:		Fax Number:	Telephone:	
	Name of Health Care Provider:		Fax Number:	Telephone:	
	Name of Health Care Provider:		Fax Number:	Telephone:	
	Name of Psychosocial Clinician:		Fax Number:	Telephone:	

C L I N I C A L	Primary Diagnosis / Known Metastases & Summary of Progression of Disease:					
	<i>Date of Diagnosis:</i>					
	Urgency of Referral:	Immediate Attention: <input type="checkbox"/>	Attention Within 2 Weeks: <input type="checkbox"/>			
	Estimated Prognosis:	Less than one week <input type="checkbox"/>	Less than one month <input type="checkbox"/>	1 to 3 months <input type="checkbox"/>	3 to 6 months <input type="checkbox"/>	Over 6 months <input type="checkbox"/>
	Treatment History: ChemoTx (date of last Tx). Radiation Therapy (where & when). Further treatment planned? Specify. Recent Investigations (Please attach information).					
	Current Issues: (Symptom Management / Psychosocial / Spiritual / Functional Decline)					

I N F O R M A T I O N	Past Medical History:	
	Past/Present Alcohol Use:	Smoker:
	Allergies or Medication Intolerances (Please Describe):	
	Current Medications: (Specify doses and frequency)	

C U R R E N T S T A T U S C O M M U N I C A T I O N A L	<u>Independent</u>	<u>Partial Assist</u>	<u>Complete</u>	
	Ambulation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transfers:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Continenence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ability to feed self:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:				
COGNITION:	No issues identified <input type="checkbox"/>	Intermittently Confused <input type="checkbox"/>	Consistently Confused <input type="checkbox"/>	
MOOD:	Anxious <input type="checkbox"/>	Depressed <input type="checkbox"/>	Agitated <input type="checkbox"/>	
BEHAVIOUR	Appropriate <input type="checkbox"/>	Inappropriate (Comment): <input type="checkbox"/>		
C O M M U N I C A T I O N	<input type="checkbox"/> English is spoken and understood <input type="checkbox"/> Other Language: _____			
	Communication barriers:			
I N F O R M A T I O N	Support System / Network:			
	If currently hospitalized - has the option of discharge home been explored?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Barriers to discharge home are:			
	Patient and family are aware of referral to Palliative Care Program?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Is client / family in agreement with referral to a Palliative Care Consult if needed?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
The Following Documentation Must Be Completed By A Physician or Nurse Practitioner <i>Completion of this form does not mean patients will be registered on the WRHA Palliative Care Program.</i> <i>After the information on this form has been reviewed, you will be notified in writing regarding acceptance for registration on the WRHA Palliative Care Program.</i>				
<p>Discussion regarding "End of Life" care wishes and expectations is a natural and important component of the process of initiating an application for registering on the Palliative Care. The application usually reflects a transition in focus of care and in hoped-for outcomes. Such discussions are best undertaken by the health care providers with whom a relationship has already been established; this would usually be the referring physician or nurse practitioner.</p> <p>Registration on the WRHA Palliative Care Program requires that the patient (or family, if the patient is not competent) is not expecting attempted resuscitation in the event of the cessation of cardiac and/or pulmonary function. Patients should not be undergoing or planning a course of treatment with expectations of monitoring for and intervening for complications in a manner other than comfort-focused (this usually refers to chemotherapy).</p>				
Acceptance of "Do Not Attempt Resuscitation" (DNAR) by patient (or family if patient not competent)? Yes <input type="checkbox"/> No <input type="checkbox"/>				
The following issues have been discussed:				
1. Does the patient have a Health Care Directive ("Living Will") or Advance Care Plan?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
2. If "No", has this been discussed?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
Has there been discussion of treatment issues related to end of life care? (antibiotic use, blood transfusions, fluids, etc)		Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Has the patient been informed of diagnosis and prognosis?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "No", please explain:				
4. Has the family been informed of diagnosis and prognosis?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "No", please explain:				
Other comments:				
Physician / Nurse Practitioner Follow-Up:				
1. The Palliative Care Drug Access Form has been completed and is included with application for registration		Yes <input type="checkbox"/> No <input type="checkbox"/>		
2. Will you accept consultation by a Palliative Care Physician Consultant if indicated?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Is the Primary Care Provider aware of referral?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
4. Will you continue to be the Primary Care Provider while the patient is out of the hospital?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
5. Will you continue to be involved in the patient's care?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
6. If you will not be the Primary Care Provider, who will? Name:		Telephone: _____		
Physician's or Nurse Practitioner's Signature:		Name (Please print):	Date:	
FOR OFFICE USE ONLY:				
Accepted: <input type="checkbox"/>		Pending: <input type="checkbox"/>	Rejected: <input type="checkbox"/>	
Explanation (Pending / Rejected):		Date: _____		