ADMISSION REFERRAL TO HOSPICE RENFREW

Please FAX completed form to:
613-432-3618

Admission required:
- ☐ Immediately
- ☐ In Future
- ☐ For Pain & Symptom Management (short stay)

Referral Principles

Completion of this referral is a request for admission to the Hospice Renfrew. Please indicate above if request is for immediate admission, future admission or PSM.

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 that referred patients will have had an assessment by one of the following partners:

- RPCT
- HCC SS Care Coordinator
- 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. *All information provided must be accurate and recent.***

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to assist in determining admission to Hospice Renfrew based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Resident Care Manager at Hospice Renfrew (459 Albert Street, Renfrew, Ontario, K7V 1V8).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):_____

Address:_____City:_____

Province:_____Postal Code: _____ Telephone/Cell: _____

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 (final days to weeks) ☐ Management of symptoms r/t disease with planned discharge (typically 2 week admission)
☐Respite (maximum two weeks with discharge plans in place before admission) ☐ Family – difficulty coping
☐ Other (details) _____

Hospice Renfrew Services

Short-stay Admission for Pain & Symptoms Management and/or Respite	**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 admission will not be accepted for the sole purpose of MAiD.

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 where life expectancy exceeds days to weeks
- They and their families express the wish to return home
- Care needs can be met at home or in a more appropriate facility
- Level of pain and symptom management is more complex than that which is available at the Hospice.
- ***All patients must be made aware of these criteria and agreeable before admission to the Hospice.*** **Initials of referrer _____**

Referral Information

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

CCAC involvement: ☐Yes ☐No HCCSS 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._____

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 _____

Current Infections**:** ☐ Yes ☐ No Describe: _____ Covid**:** ☐ Yes ☐ No

Covid Vaccinations**:** ☐ None ☐ ____ # Doses Date of most recent dose**:** _____

☐ MRSA+ ☐ VRE+ ☐ C-diff ☐ Outbreak unit ☐ Other _____

Details of precautions and/or treatments 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 HCCSS 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 ☐ Behavioral issues ☐ Social isolation

Comments:

Goals of Care

- **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 ☐ Uncertain

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

- **SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION**

Hospice Renfrew will allow the provision of Medical Assistance in Dying ("MAID") within its premises if no other options are available. Hospice Renfrew will NOT admit patients for the sole purpose of receiving MAiD. Patients must be eligible for admission based on criteria outlined in this document.

All potential candidates for admission must be advised of this policy.

MAID Discussion

☐ Discussion has not occurred

Hospice Renfrew policy on MAiD discussed with person requesting admission on _____ (date).

By: _____ (name and designation).

MAID requested? ☐ Yes ☐ No

MAID process initiated? ☐ Yes ☐ No If yes, date: _____ and Network: _____

Date scheduled for MAiD procedure (dd/mm/yyyy): _____Location: _____

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

**Required ** 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 ☐ Cognitive Deficit/Delirium

☐ 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 History of choking? ☐ Yes ☐ No

Equipment Care Needs

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

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

CADD Pump ☐ Yes ☐ No Type: _____ Medication: _____ _____

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		

Oxygen Requirements

Does the patient require supplemental Oxygen ☐ Yes ☐ No

O2 delivered via: _____ @ _____ L/min

Other treatments: _____

Wound sites

Does the patient have existing wounds? ☐ Yes ☐ No

Type: _____

Current treatment: _____

Type of dressing in use: _____

Date of last treatment/dressing change: _____

Special instructions: _____

Transfer Requirements

Patient's current weight: _____ lbs.

Current transfer requirements: Pivot _____ X _____ assist. Lift _____ Sling size _____

Other significant information: _____