DOCTOR'S REFERRAL FORM
TO PALLIATIVE MEDICINE PHYSICIAN PROGRAM

CRITIERIA FOR PALLIATIVE CARE PHYSICIAN CONSULTATION

A diagnosis of a life threatening illness considered palliative requiring:
*****Please indicate the appropriate request. ******

- ☐ **End of Life Care – Prognosis Three Months or Less.**
- ☐ **Malignant Pain and Symptom Management – Consult Only.**
- ☐ **Non-Malignant End of Life Care – Consult/Shared Care Only.**

For *all* End of Life referrals, the Prognosis should already have been discussed
Home visits are NOT intended to replace Primary Care responsibilities
Our Program does not accept referrals for Chronic Non-Malignant Pain

C/O: The Hospice of Windsor and Essex County Inc.
6038 Empress Street, Windsor, Ontario N8T 1B5
Fax: (519) 974-7672 **Phone: (519) 974-7100**

For Urgent Referrals: Call to speak to the Palliative Care coordinator at ext. 2254. Referrals are triaged at the time of receipt. Urgent faxes will NOT be accepted without telephone contact.

Date: _____

Patient's Name: _____ **Address:** _____

D.O.B._____ **Phone #:**_____

OHIP#:_____ **Ver**: _____ **WRCC#**_____

Patient location: Home ☐ WRH-M ☐ WRH-O ☐ LDMH ☐ **Prognosis:**_____

DIAGNOSIS: _____

SYMPTOMS/ISSUES:

_____

In order to properly triage your referral, please be sure to provide all necessary information to avoid delays in your patients being seen. Incomplete referrals will be returned for your review. Minimum requirements include:
Past Medical History ☐ Current Medications ☐ Consults and Progress Notes ☐
Discharge Summaries ☐ Advanced Directives/POA/DNR/HPP for EOL care ☐
All recent and relevant investigations including imaging, laboratory and biopsy results ☐

Patient last seen: _____ **Is CCAC involved:** Yes ☐ No ☐
Is patient aware of referral: Yes ☐ No ☐ **Are you MRP:** Yes ☐ No ☐

Referring Physician: _____ **OHIP Billing Number**_____
****By signing below, I understand that I will continue to be involved in the ongoing care of this patient. **Physician Signature:** _____