Sinai Health | Temmy Latner Centre for Palliative Care

Temmy Latner Centre for Palliative Care
Community Palliative Care Physician Referral Form

To avoid a delay in our response to your request, please complete all sections of this form & include the following information:

☐ Relevant admission, consult & discharge notes ☐ Imaging reports ☐ Recent laboratory results

We will strive to see your patient within 1-2 weeks. Incomplete referrals will delay our ability to care for your patient.

☐ This person needs to be prioritized over other patients, if so, please call our office today: (416) 586-4800 x 7884.

PATIENT INFORMATION

Last name: _____ First name: _____

Birth date (DD MM YYYY):_____

Health card number: _____ Version code: _____

Sex: _____ Gender Identity (if known): _____ Preferred Pronouns (if known): _____

Home address: _____ Apt: _____ Entry code: _____ Postal code: _____

Home phone: _____ Cell phone: _____

Primary language: _____ Translator's name: _____ Phone: _____

Current location: ☐ Home ☐ Hospital/PCU: _____ Anticipated discharge date: _____

OTHER CONTACT INFORMATION

Primary contact

Name	Relationship	Home phone	Cell phone

Alternate contact(s)

Name	Relationship	Home phone	Cell phone

MEDICAL INFORMATION

Primary reason for referral
☐ End-of-life care ☐ Symptom management ☐ Other: _____

Primary palliative diagnosis: _____ **Date of diagnosis:** _____

Other relevant diagnoses/comorbidities: _____

Individual aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

Family aware of: Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

Anticipated prognosis: ☐ < 1 month ☐ < 3 months ☐ < 6 months ☐ < 12 months ☐ uncertain

Determined by (name and phone number): _____

Functional status: ☐ Able to get out to appointments ☐ Confined to house ☐ Confined to bed

DNR: ☐ Yes ☐ No ☐ Unknown

Is this patient actively waiting for a palliative care unit bed? ☐ Yes ☐ No

Infection control: ☐ MRSA / VRE / ESBL

Patient / Family key issues & concerns (e.g. domestic violence, substance abuse, translator required)

FAMILY PHYSICIAN INFORMATION

Name: _____ Phone: _____ Fax: _____

Family physician aware of referral request ☐ Yes ☐ No

REFERRAL SOURCE INFORMATION – must be complete before a referral will be accepted

Individual completing form (please print): _____ Phone: _____ Fax: _____

Referring physician or NP (please print): _____ Phone: _____ Fax: _____

Referring physician's or NP's billing number: _____ Date of referral :(DD/MM/YYYY): _____

Please fax the completed referral form & health records to (416) 586-4804 & call to confirm that we have received the referral form. Thank you for referring to our program.