Ed's House Northumberland Hospice Care Centre

Bed Referral Form

Addressograph

TO ALL PALLIATIVE CARE PROVIDERS

ONLY if client is an existing Northumberland Palliative Care Community Team (PCCT) client, with Hospice Clinical Navigation supports in place, complete box below. Otherwise complete entire document (if unsure please call Hospice Services at 1-855-473-8875)

☐ Consult note from EMR (including diagnosis, current symptoms, and any concerns)
☐ Current Medication List
☐ Completed *Palliative Care Order Set*
☐ Complete page 2 only

Home Address: _____ **Apt:** _____ **Entry Code:** _____ **Postal Code:** _____

Home phone number: _____ **Alternate number:** _____

Date of birth: (DD/MM/YY): _____ **Gender**: _____

Health card number: _____ **Version code**: _____

Primary language(s): _____

Current location: ☐ Home ☐ Residential Hospice ☐ Other:_____

☐ Hospital _____ Anticipated hospital discharge date: _____

Primary Palliative Diagnosis: _____

Other relevant diagnosis/symptoms: _____

Substitute Decision Maker/ POA: _____ **Contact #:** _____

If cancer diagnosis: ongoing treatment: ☐ Yes ☐ No Describe: _____

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

Infection Control: ☐ MRSA/VRE (+) ☐ C-DIFF (+) ☐ Other *(specify precaution)*: _____

Allergies: ☐ Yes ☐ No specify:_____

Current PPS:_____ **Pharmacy** (name and number) If Known: _____

Please include most recent medication list (Include complementary alternative and over-the-counter medications)

Special care needs: (please check all that apply)☐ SC ☐ Infusion pump(s) ☐ P.I.C.C. line(s) ☐ Porta Cath
☐ Tracheostomy ☐ Thoracentesis☐ Paracentesis
☐ Drains/Catheter (specify): _____
☐ Oxygen: rate: _____
☐ Wound care (specify): _____
☐ Therapeutic surface (specify): _____
☐ Other needs: _____

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Any additional information: Details of social situation, including any needs/concerns of the family:

Individual Completing Form: _____ Tel: _____

(Referring) Physician: _____ Tel: _____

Who will be MRP at Ed's House: _____

*****Primary Health Care Provider must have 24-hour coverage by self or buddy system*****

MRP Daytime Phone: _____

MRP Afterhours Phone: _____

CPSO#: _____ OHIP Provider#: _____

☐ I am interested in continuing to provide palliative care to my client, but need help with 24-hr coverage

☐ I would like to completely hand over care, please assign a palliative physician

Date of Referral: (DD/MM/YY): _____

Please fax Completed Form to 289 252-0676

HONOURING THE JOURNEY
ED'S HOUSE NORTHUMBERLAND HOSPICE CARE CENTRE

An Integral Service of

COMMUNITY CARE NORTHUMBERLAND