Timiskaming Hospice Palliative Care

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REFERRAL FORM

Client's Name _____ Birthdate: _____Age:_____

Location: Hospital □ Home □ or *Long Term Care Home* □ *specify room #:* _____

Home Address: _____ Postal Code:_____

Telephone:_____ Language: English □ French □ Other: _____

Significant Other(s)	Relationship to Client	Phone Number

Diagnosis: _____

Medical Conditions and/or Limitations: _____
_____

Attending Physician:_____ Phone Number_____

Client has knowledge of disease / illness? NO □ YES □ **PPS _____ %**

Client &/or Family Agree with Referral? NO □ YES □ Consent signed YES □

Reason for referral: Client Support □ Family Support □ Caregiver Relief □
Resource material □ Bereavement Follow-up □ Other_____
Concerns_____

Referred by _____ Agency_____ Date:_____

Office Use Only:			Client Identification #: _____	
Assessed By:	**Date:**	**Services Provided**:	**Consultation and/or Volunteer(s) Assigned**	**Hours**
Referred To:		Client Support □ Family Support □ Caregiver Relief □ Pain & Symptom Mgmt □ Resource material □ Bereavement Follow-up □ Other: _____		
Discontinued:			**Co-ordinator's Hours**	
Deceased:			**Total Hours:**	