# Common Hospice Palliative Care (HPC) Referral Form

(Use menu at left of screen – sign to access the add text and checkmarks; then print and fax to Hospice)

☐ Hospice Kirkland Lake – 145 Government Rd. East - Fax 705-568-2106 Phone 705-568-2135

☐ Hospice Englehart – 61 Fifth Street Fax 705- Phone 705- 544-2301 ext. 5245

☐ Hospice Temiskaming Shores – 421 Shepherdson Rd. - Fax 705-647-8011 Phone 705-647-1088 ext. 2409

Draft Jan 9 2017 version 9

## REFERRING PRINCIPLES

Completion of this referral is a request for referral and admission to Hospice Care

I have informed the patient and/or the patient's substitute decision-maker (SDM) about the purpose for the collection of the information in this application which will be used to make referral to the Palliative Care Coordinator/Lead to determine eligibility for admission to the Hospice Care based on the needs of the patient. He/ She is aware that their consent can be withdrawn at any time by writing to the Privacy Officer of the hospice / hospital identified above.

I have informed the patient and/or SDM about the philosophy of hospice palliative care* which focuses on supporting any issues that may arise including physical, disease management, psychological, social, spiritual, practical, loss, grief and end of life / death management. The goal is to provide management of pain and other symptoms to achieve comfort, reduce suffering and improve the quality of life and dying. (* CHPCA Model to Guide HPC 2002)

☐ ***Yes, I have completed this task***

Referral completed by: _____ Date: _____ Title: _____

Organization: _____ Telephone: _____ Pager or Cell Phone: _____

## REASON FOR REFERRAL (Select all that apply)

☐ Symptom Management and EOL Care

☐ End of Life Care – EOL (last days to week)

☐ EOL Care Needs exceed the capacity/supports available at home (family/primary caregivers)

☐ EOL Care Needs exceed the capacity/supports available in the community

☐ Patient or family do not wish home death

☐ Other: _____

## SECTION A – PATIENT DEMOGRAPHICS / GENERAL INFORMATION

| | | | |
|---|---|---|---|
| Name: | | | Date of Birth: (D/M/Y) |
| Age: | Gender: | Spiritual Support: | Telephone: |
| Address: | | City: | Province: |
| Postal Code | | Ontario Health Card #: | Lives Alone: Yes No |
| Preferred Language: English French Other: | | Marital Status: | |

| CONTACTS | Name & Phone Number | Relationship | Address (Incl. City/Province/Postal Code) |
|---|---|---|---|
| POAPC – Attorney for Personal Care: Document Completed Yes No (If yes include Copy of Document ) | Name: Tel: | | |
| If No - Substitute Decision Maker (SDM) Identified Yes No | Name: Tel | | |
| Primary Contact (s): State reason contact would be made. | Name: Tel: Reason for contact: | | |

## SECTION A – PATIENT DEMOGRAPHICS / GENERAL INFORMATION

| PHYSICIANS/PROVIDERS | Name | Telephone | Fax |
|---|---|---|---|
| Attending Physician | | | |
| Primary Care Provider | | | |

PRESENT LOCATION OF PATIENT

| Home: | Facility//Unit: | Contact: | Tel. & Ext.: |
|---|---|---|---|

NECCAC Care Co-Coordinator: Tel. & Ext.:

Visiting Contract Nurse Agency: Tel. & Ext.:

Patient of NECCAC? Yes No

LEVEL OF TREATMENT HAS BEEN DISCUSSED WITH PATIENT AND SDM / POAPC

Has admission to Hospice been discussed w/Patient? Yes No

Has admission to Hospice been discussed w/Patient's family? Yes No

Most Responsible Physician / NP agreeable w/Hospice admission? Yes No

GENERAL HISTORY / DESCRIPTION OF ILLNESS (END OF LIFE DIAGNOSIS):

CULTURAL NEEDS:

FAMILY NEEDS:

ESTIMATION OF PROGNOSIS (PPS) – Palliative Performance Scale (PPI) – Palliative Performance Index

| Physician / Nurse Practitioner indicating prognosis: | Less than 1 month ___ Less than 3 months ____ | PPS% _____ (appendix A)<br>PPI _____ (appendix B) |
|---|---|---|

Patient aware of prognosis? Yes No Family/SDM aware of prognosis? Yes No

MEDICATIONS

Allergies:

List of current medications attached: ☐

## SECTION B – MEDICAL INFORMATION

Attach appropriate medical and nursing notes ☐

RELEVANT MEDICAL / PSYCHOSOCIAL HISTORY (Including recent course of illness precipitating referral):

Patient Height: Patient Weight:

RECENT TREATMENTS

| Chemotherapy: Yes No<br>If Yes, Date of Last Treatment: | Radiation: Yes No<br>If Yes, Date of Last Treatment: |
|---|---|

SURGERIES

| Date | Procedures |
|---|---|
| | |
| | |

| PATIENT CARE NEEDS |
|---|
| Functional Level : Current PPS % _____ Previous PPS % (note change within last two weeks): |
| Bladder Function: Continent ____ Incontinent ____ Foley – Size _____ Date to be changed _____ |
| Bowel Function: Continent ____ Incontinent ____ Date of Last BM _____ |
| Ostomy Y/N Colostomy Ileostomy Nephrostomy Rt / Lt Bilateral Ileoconduit Appliance Information_____ |
| Diet Type _____ Appetite: Normal Fair Poor Sips Dysphagia Special diet/Swallowing Instructions_____ |
| Level of Consciousness Alert Lethargic Semi-Comatose Comatose Delirium-Hypoactive Delirium-Hyperactive Dementia |
| Behaviours: |

| ADDITIONAL PATIENT CARE NEEDS |
|---|
| Specialty Care Needs: Tracheostomy Size & Brand: Frequency of Suctioning _____ |
| PCA Infusion: Y/N Symptom treated: Oxygen: Y/N Litre flow: NP Mask Oximizer |
| Epidural: Gastrostomy Tube: Y/N Purpose: |
| Isolation: Y/N Type of Isolation required : Type of Infection: |
| Wound Care: Y/N Site: Dressing Type and Frequency: |

SYMPTOMS

| SYMPTOMS | ESAS SCORE 0 – 10 SCALE | DESCRIPTION OF SYMPTOMS |
|---|---|---|
| Anxiety | | |
| Appetite | | |
| Constipation | | |
| Depression | | |
| Dyspnea / Shortness of Breath | | |
| Fatigue / Drowsy | | |
| Feeling of Well Being | | |
| Nausea | | |
| Pain | | |
| Other _____ | | |

| ADVANCE CARE PLANNING |
|---|
| Values, Wishes, Beliefs Expressed by patient that are to be shared: |
| |
| |
| |
| Funeral Arrangements: Yes No Details: |
| |

| GOALS OF CARE DISCUSSION |
|---|
| Outline Patient's Goals of Care: |
| |
| |
| |
| |
| |
| |

DNR: ☐ Yes ☐ No (Do Not Resuscitate) * Patients require a DNR order to be admitted to the Hospice Suite

If No, please explain:
- ☐ Discussion has not occurred
- ☐ Patient requests full code
- ☐ Full code is appropriate

If Yes, please select:
- ☐ DNRC Form completed (Do Not Resuscitate Confirmation Form)
- ☐ DNR discussed and confirmed with Patient/SDM

Date of most recent discussion regarding DNR: _____ by _____.

## IDENTIFICATION OF ADMISSION CRITERIA FOR PROGRAMS

### HOSPICE SUITE – ADMISSION CRITERIA

- □ have a progressive life limiting illness,
- □ have a life expectancy which is anticipated to be less than 3 months,
- □ Palliative Performance Score (PPS) of 40% or less,
- □ live in the district of Timiskaming & area, or wish to return to this area to be with family at end of life,
- □ has been assessed by a Physician, or N.P. within the last two weeks
- □ no longer WISH TO receive active disease modifying treatment,
- □ may have had discussions regarding advance care planning and goals of care,
- □ "DNR" has been established through the physician's order, and DNRC form. (DNR – Do Not Resuscitate; DNRC – Do Not Resuscitate Confirmation Form)
- □ have consented to admission to hospital / hospice care, and will be accompanied by family members as required.

**Exclusion Criteria:**

**Individuals will not be admitted to the HOSPICE if:**

- ❖ they wish to continue active/curative treatment
- ❖ they have medical or nursing needs whose complexity/or supervision requires a nurse to patient ratio that is greater than can be accommodated by the Hospice program's model of care
- ❖ they exhibit behaviors that are abusive / aggressive and may cause harm to self, others or property
- ❖ they exhibit behaviors (including wandering) that require closer monitoring in another location on the nursing unit.

### HOSPICE PALLIATIVE COORDINATOR/LEAD USE ONLY

### REVIEW OF REFERRAL AND OUTCOMES

| | | | |
|---|---|---|---|
| Hospice KIRKLAND LAKE | Date Accepted □ | Date Declined □ | Reason: |
| Hospice ENGLEHART | Date Accepted □ | Date Declined □ | Reason: |
| Hospice TEMISKAMING SHORES | Date Accepted □ | Date Declined □ | Reason: |
| PLACED ON WAIT LIST | | | |

Referral Review completed by: Title:

Referral In person consultation completed by: Title:

Organization: _____ Telephone: _____ Pager or Cell Phone: _____

Notification of acceptance or decline discussed with REFERRING AGENT - Date _____

Notification of acceptance or decline discussed with PATIENT/FAMILY - Date _____

Notify patient/family of date and time of transfer to Hospice Care _____

Notify Nursing Department of date/time of transfer to Hospice Care _____

*APPENDIX A*

A Circle Of Care
Victoria Hospice SOCIETY

# Palliative Performance Scale (PPSv2)
## version 2

| PPS Level | Ambulation | Activity & Evidence of Disease | Self-Care | Intake | Conscious Level |
|---|---|---|---|---|---|
| 100% | Full | Normal activity & work<br>No evidence of disease | Full | Normal | Full |
| 90% | Full | Normal activity & work<br>Some evidence of disease | Full | Normal | Full |
| 80% | Full | Normal activity *with* Effort<br>Some evidence of disease | Full | Normal or reduced | Full |
| 70% | Reduced | Unable Normal Job/Work<br>Significant disease | Full | Normal or reduced | Full |
| 60% | Reduced | Unable hobby/house work<br>Significant disease | Occasional assistance necessary | Normal or reduced | Full<br>or Confusion |
| 50% | Mainly Sit/Lie | Unable to do any work<br>Extensive disease | Considerable assistance required | Normal or reduced | Full<br>or Confusion |
| 40% | Mainly in Bed | Unable to do most activity<br>Extensive disease | Mainly assistance | Normal or reduced | Full or Drowsy<br>+/- Confusion |
| 30% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Normal or reduced | Full or Drowsy<br>+/- Confusion |
| 20% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Minimal to sips | Full or Drowsy<br>+/- Confusion |
| 10% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Mouth care only | Drowsy or Coma<br>+/- Confusion |
| 0% | Death | - | - | - | - |

**PPS used with Permission from Victoria Hospice Society*

*APPENDIX B*

iaBPG

http://ltctoolkit.rnao.ca/sites/default/files/resources/EndofLifeCare/AssessmentTools/Pg101_PPI_EndofLifeBPG2011.pdf

**Nursing Best Practice Guidelines**

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## Palliative Prognostic Index (PPI)

The PPI relies on the assessment of performance status using the Palliative Performance Scale (PPS, oral intake, and the presence or absence of dyspnea, edema, and delirium.

| Performance status/Symptoms | Partial score |
|---|---|
| ***Palliative Performance Scale*** | |
| 10–20 | 4 |
| 30–50 | 2.5 |
| ≥60 | 0 |
| ***Oral Intake*** | |
| Mouthfuls or less | 2.5 |
| Reduced but more than mouthfuls | 1 |
| Normal | 0 |
| ***Edema*** | |
| Present | 1 |
| Absent | 0 |
| ***Dyspnea at rest*** | |
| Present | 3.5 |
| Absent | 0 |
| ***Delirium*** | |
| Present | 4 |
| Absent | 0 |

**Scoring**
PPI score > 6 = survival shorter than 3 weeks
PPI score >4 = survival shorter than 6 weeks
PPI score ≤4 = survival more than 6weeks

*Reprinted from Journal of Pain and Symptom Management, Vol. 35, No. 6, Stone, C., Tierman, E., & Dooley, B., Prospective Validation of th Palliative Prognostic Index in Patients with Cancer, 617–622, Copyright (2008).*