**Palliative Medicine Referral – Rexdale Medical Centre**

123 Rexdale Blvd., Unit 2, Toronto, ON M9W 1P1 **P**: 416-743-5853 **F**: 416-743-1358

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_ First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Card Number:** \_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ **Version Code:** \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Home |  | Residence Hospice |  | Other (please specify) |
|  |  |  |  |  |  |
|  | Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | Anticipated Date of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Date of Birth** (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Location:**

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postal Code:**\_\_\_\_\_\_\_\_\_

**Home Phone:** (\_\_\_\_) - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ **Alternative:** (\_\_\_\_) - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Reason for Referral:** |  |
| **Relevant History:** |  |

**Resuscitation Status:**

Do Not Resuscitate: Yes No Discussed with: Individual Yes No Family Yes No

**ESAS Score at time of updated Referral** Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Adapted from Edmonton Symptom Assessment System; 0-10 scale (0 = no symptom, 10 = symptom worst possible)*

Pain: \_\_\_\_\_ Tiredness: \_\_\_\_\_ Nausea: \_\_\_\_\_ Depression: \_\_\_\_\_ Anxiety: \_\_\_\_\_ Drowsiness: \_\_\_\_\_ Appetite: \_\_\_\_\_ Well-being: \_\_\_\_\_ Shortness of Breath: \_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Functional Status**

*Palliative Performance Scale (PPS) at time of referral*

PPS: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

|  |  |
| --- | --- |
| **List Current Medication:** |  |
| **Additional Notes/Update:** |  |

Requested By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_