



**REFERRAL FOR MARIANHILL HOSPICE**

<https://marianhill.ca/services/hospice-palliative-care/>

**Please FAX completed form to:  
613-732-3934**

**Attention: Diane Tennant DOC**

**Admission request:**

- Immediate
- Future
- Pain and symptom management
- Respite

**Referral Principles**

Completion of this referral is a request for an admission to the Marianhill Hospice. Future or back-up referrals will be accepted. Patients referred to Marianhill Hospice are triaged based on established criteria into the most appropriate care setting. To ensure sufficient and accurate information is available as part of the referral package, the expectation is referred patients will have had an assessment by one of the following partners:

- Palliative Pain and Symptom Management Consultation Service
- Hospitals
- Champlain Hospice Palliative Community Network community palliative care physicians/Home and Community Support Care Case Mgr

Please ensure a copy of the consult note is included in the referral package  **Yes, Copy attached.**

*I have informed the patient and/or the patient's substitute decision maker about the purpose for the collection of the information in this application which will be used to assist in determining admission to Marianhill Hospice based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Director of Care Marianhill Hospice (600 Cecelia Street Pembroke, ON K8A 7Z3). Consent to Admission to Marianhill Hospice has been complete.*

**Yes, I have completed this task.** Referral Completed by: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Pager or Cell Phone: \_\_\_\_\_

**Patient Demographics**

Given name: \_\_\_\_\_ Surname: \_\_\_\_\_  
 Sex:  Male  Female Date of birth (dd/mm/yyyy): \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Marital status:  Married  Single  Widowed  Divorced  Other: \_\_\_\_\_  
 Preferred language:  French  English  Other: \_\_\_\_\_  
 Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**Reason for Referral**

- End of Life Care - EOL (last days to weeks)  Patient or family do not wish home death  Symptom management and EOL care
- Symptom management with potential discharge  Respite
- Other (details) \_\_\_\_\_

**Marianhill Hospice Services**

**Acute Palliative Pain and Symptom Management or Respite Admission (depending on bed availability) : Short Stay & Symptom Control**

Patients have a non-curable, progressive, life threatening disease  
Require daily symptom mgmt. by specialist physician and team  
Presence of persistent pain or other complex/difficult symptom, Edmonton Symptom Assessment System (ESAS) ≥ 4/10  
PPS not a criteria  
Valid OHIP number

**For the very end of life: last days or weeks of life**

Patients have non-curable, progressive life threatening disease with a prognosis of less than 3 months  
Patients are not on curative therapy  
PPS equal or less than 40%  
DNR order in place  
Valid OHIP number  
Resident aware that hospice does not provide MAID

**Discharge Criteria**

**Patients who no longer meet the admission criteria will be considered for discharge when:**

The intensity and clinical expertise of the program is no longer required  
The patient's functional status stabilizes or improves to such a degree that life expectancy exceeds just a few days or weeks.  
They and their families express the wish to return home  
Their care needs can be met at home or elsewhere  
They require a level of pain and symptom management more complex than that available at the Hospice.

**Patient POA aware of Discharge Criteria**  Yes

**Referral Information**

Patient's Current Location: \_\_\_\_\_ Date of Referral Completion: \_\_\_\_\_  
CCAC involvement:  Yes  No CCAC Case Manager: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_  
Referral Completed by: \_\_\_\_\_ Tel. \_\_\_\_\_ Pager: \_\_\_\_\_  
Pharmacy in the Community: \_\_\_\_\_

**Patient's Contact Information**

First Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. \_\_\_\_\_  
Substitute Decision Maker (personal care) \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. \_\_\_\_\_  
Power of Attorney for Property \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. \_\_\_\_\_  
Attending Physician (full name) \_\_\_\_\_ Tel. \_\_\_\_\_ Pager/Cell: \_\_\_\_\_  
Referring Physician (full name) \_\_\_\_\_ Tel. \_\_\_\_\_ Pager/Cell: \_\_\_\_\_  
Family Physician (full name) \_\_\_\_\_ Tel. \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

**Medical information**

**Main Diagnosis:** \_\_\_\_\_

- Date of diagnosis (Month/year) \_\_\_\_\_
- If cancer, metastatic sites \_\_\_\_\_
- Summary of treatments (chemo, radiation, dialysis) \_\_\_\_\_  
\_\_\_\_\_
- Noteworthy complications (i.e. spinal cord compression) \_\_\_\_\_  
\_\_\_\_\_

Other Concurrent Illnesses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Noteworthy Past Medical History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_  
\_\_\_\_\_

Current weight: \_\_\_\_\_

Infections:  Yes  No

MRSA+  VRE+  C-diff  Outbreak unit  Other \_\_\_\_\_

Details of precautions in place \_\_\_\_\_

- ✓ **A medical discharge summary must accompany the patient at the time of admission**
- ✓ **It is imperative to include a copy of the Current Medication Administration Record (MAR),**
- ✓ **5 days of progress notes and the medical admission history and physical with the application.**
- ✓ **Reference Source must initiate CCAC referral prior to admission to Marianhill Hospice**
- ✓ **When coming from TOH/QCH or other site that has palliative care consultations – a consultation notes must be included.**

#### Psychosocial Situation

- Patient and/or family coping difficulties  Patient lives alone  Caregiver stress, illness  Family tension
- Substance abuse  Psychiatric issues  Behavioural issues  Cognitive deficit (dementia/delirium)  Social isolation

Comments(provide details):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Goals of Care and Advance Care Planning (Do Not Resuscitate and Medical Assistance in Dying) (select all that apply)

➤ SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

Describe Goals of Care: \_\_\_\_\_

DNR Order in place:  Yes  No

If yes, please select:

DNR Discussed and Confirmed with Patient/SDM

Date of most recent discussion (dd/mm/yyyy): \_\_\_\_\_

If No please discuss with patient and obtain DNR order

DNR Order Obtained  Yes

Date of DNR Order obtained (dd/mm/yyyy): \_\_\_\_\_

**\*Patients will be required to sign admission agreement and specific form acknowledging that Marianhill Hospice does not provide CPR**

➤ SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

Marianhill Hospice does not permit the provision of Medical Assistance in Dying ("MAID"). Authorization for admission to Marianhill Hospice must be signed and completed by the capable applicant.

**Capable applicants will be required to sign Authorization for admission to Marianhill Hospice form acknowledging that Marianhill Hospice does not provide MAID**

Completed

**Family Physician and Palliative Care Consultation Team Contact**

Has the referring professional contacted the patient's family physician to provide follow-up medical care at Hospice?  Yes details \_\_\_\_\_  No

Has the referring professional contacted a Palliative Care Consult Team?  Yes  No  
 If yes, I have attached the consult summary  Yes

\*\*Please note that contact from physician to physician may be preferred for admission approval.

**Patient Symptom and Needs Profile: Palliative Performance Scale (PPS)**

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

**Symptoms: Edmonton Symptom Assessment Scale (ESAS)**

Can the patient complete the ESAS?  yes  no Date Completed: \_\_\_\_\_

If no, what is the reason?  Patient too ill (PPS < 30%)  Language barrier  Cognitively impaired/Delirious

Other: \_\_\_\_\_

**ESAS Scores** (please indicate score on the scale of 0 to 10. 0 indicates symptom is absent, while 10 is the highest severity of the problem).

Pain \_\_\_\_\_ Fatigue \_\_\_\_\_ Nausea \_\_\_\_\_ Depression \_\_\_\_\_ Drowsy \_\_\_\_\_ Appetite \_\_\_\_\_

Feeling of wellbeing \_\_\_\_\_ Shortness of breath \_\_\_\_\_ Other problem \_\_\_\_\_ details \_\_\_\_\_

**Swallowing & Intake**

Difficulty swallowing or chewing  yes  no Current diet order: \_\_\_\_\_

Intake:  Normal  Reduced  Sips only  NPO

### Equipment Care Needs

IV in Use:  Yes  No Access:  Peripheral  Sub Q  
 Central Line  Yes  No Type: \_\_\_\_\_ Date of last flush: \_\_\_\_\_  
 PICC  Yes  No Type: \_\_\_\_\_ Number lumens: \_\_\_\_\_  
 CADD Pump  Yes  No Epidural  Yes  No Intrathecal  Yes  No  Other \_\_\_\_\_

**Elimination:** Last Bowel Movement (Date/Time/Quantity) : \_\_\_\_\_  
 Last Void (Date/Time/Quantity): \_\_\_\_\_  
 Foley Catheter:  Yes  No Size/type: \_\_\_\_\_ Date inserted: \_\_\_\_\_

Elimination Device	Supplies required	Date of last change
<input type="checkbox"/> Colostomy		
<input type="checkbox"/> Ileostomy		
<input type="checkbox"/> Nephrostomy		
<input type="checkbox"/> Ileo-conduit		

Supplemental Oxygen  Yes  No LPM \_\_\_\_\_  NP  Mask Other \_\_\_\_\_  
 BiPAP:  Yes  No CPAP:  Yes  No Settings: \_\_\_\_\_ Frequency: \_\_\_\_\_ Does patient own mask?  Yes  No  
 Tracheostomy:  Yes  No Size and brand: \_\_\_\_\_  Cuffed  Uncuffed  
 Is the patient suctioned?  Yes  No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Enteral feeding:  Yes  No Route:  PEG  PEJ  N/G Bolus  Continuous   
 Product Used: \_\_\_\_\_ Volume per feed: \_\_\_\_\_ Hourly Rate: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Flush  Yes  No Frequency: \_\_\_\_\_ Volume per Flush: \_\_\_\_\_  
 Chest tubes:  Yes  No  Gravity  PleurX  Continuous  Suction: \_\_\_\_\_  Intermittent \_\_\_\_\_ mmH<sub>2</sub>O  
 Date of last drainage: \_\_\_\_\_ Type of mattress in use: \_\_\_\_\_

Wound sites	Stage	Type of dressing in use

#### Additional Information
