Brameast
Family Health Organization

Brameast Community Palliative Care Referral Form

To avoid any delay in our response to your request, please complete all sections of the form and enclose any imaging reports, recent lab results and pertinent consult notes

PLEASE FAX REFERRALS TO: 905-792-2901

☐ **One Time Consult**
☐ **Ongoing Palliative Care**

☐ **Urgent** (< 48hrs) - please contact our team at 416-371-0733
☐ **Elective** (typically seen 1-2 weeks)

Patient Information:

Last Name: _____ **First Name**: _____

Date of Birth (Day, Month, Year): _____ **Gender**: _____ **Primary Language**: _____
Health Card Number (with version code): _____
Address: _____

Home Phone Number: _____ **Cell Phone Number**: _____

Primary Contacts*:*

Name	*Relationship*	*Phone Number*

Current location: ☐ Home ☐ Hospital – Anticipated Date of Discharge: _____

Palliative Care Diagnosis: _____ **Date of Diagnosis**: _____

Individual Aware of Diagnosis and Prognosis: ☐ Yes ☐ No

Anticipated Prognosis (if known): ☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ uncertain
Palliative Performance Scale (PPS): _____

Patient Interested in MAiD: ☐ Yes ☐ No

Oncologist/Specialist: _____ **Location of Treatment**: _____

Medical records attached: ☐ Yes (Please include documentation of diagnosis, prognosis, relevant consults, etc.)

DNR: ☐ Yes ☐ No **EDITH* Form in Place**: ☐ Yes ☐ No **CCAC Services Started**: ☐ Yes ☐ No

Patient/Family Concerns Team should be aware of (i.e. substance abuse, psychosocial concerns, symptom management):

Referral Information:

Name of Family Physician: _____ *Phone Number*: _____

Family Physician aware of referral: ☐ Yes ☐ No *Fax Number*: _____

Referring Physician/NP (please print): _____ **Billing number**: _____
Referring Physician/NP Signature: _____ **Date of Referral**: _____
Referring Physician/NP PHONE #: _____ **FAX #**: _____

EDITH = expected death in the home