Outpatient Palliative Care Clinic Referral Form

825 Coxwell Ave, Toronto, ON. M4C 3E7   Tel: 416 469 6580 ext 2847   Fax: 647-480-6313

DATE:

1. Patient Demographics

Name: ____

DoB: ____

OHIP #: ____

Address: ____

Phone Number(s): _____________________________________

2. Referring Physician Information

Name: ____

CPSO#:____

Billing Number ____

Phone Number(s): _____________________________________

Reason for referral

☐Symptom Management

Check: ☐pain ☐shortness of breath ☐nausea/vomiting

☐Advanced Care Planning

☐Other: ____

3. Code status

☐Full Code
☐DNR
☐Have not discussed

4. Goals for consult

☐Consult only
☐Consult + primary management of *palliative care needs*

★★★ **Please attach most recent clinical notes**

<u>Referral Criteria</u>

Life Expectancy <24 months + chronic disease/terminal illness
Patient resides in East York or Scarborough