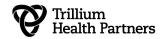


### THP PALLIATIVE CARE AMBULATORY **REFERRAL FORM**

| Account Number:    |
|--------------------|
| Patient Name:      |
| Date of Birth:     |
|                    |
| Gender:            |
| Healthcard Number: |

| Telephone Number: 905-813-1100 extension 5143<br>Fax Number: 905-813-4024  | Healthcard Number:                            |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Patient Conta  | Unit Number:ct Information                    |  |  |  |  |  |  |  |
| 1 2110110 5 011111   |   |  |  |  |  |  |  |  |
| Street Number: Apt/Unit Number:  | City-Province:                                |  |  |  |  |  |  |  |
| Postal Code: Home Number: Other I  | Phone Number: Spoken Language:                |  |  |  |  |  |  |  |
| Interpretation required: Yes No Alternate Contact Name: Alternate Contact Number:  |   |  |  |  |  |  |  |  |
| Person to contact with Appointment: Patient Alternate  |   |  |  |  |  |  |  |  |
| Family MD Name:  | MD Contact Phone Number:                      |  |  |  |  |  |  |  |
| Referral Inf   | ormation                                      |  |  |  |  |  |  |  |
| Patient had consented to Palliative Referral  LHIN Palliative Care Home Care Referral Completed  Primary Diagnosis:  |   |  |  |  |  |  |  |  |
|  | not wish to know<br>not wish to know          |  |  |  |  |  |  |  |
| Prognosis: <2 weeks 1 month <3 months <6 months   Palliative Performance Scale: (See page 2 for Palliative Perform 10% 20% 30% 40% Reason for Referral / Specific Concerns:  |   |  |  |  |  |  |  |  |
| URGENCY Urgent (<2 week) e.g. pain or symptom crisis, rapid decline Routine (2-4 weeks) e.g. psychosocial: family support, pain/symptom management, advanced care planning; information/education regarding palliative care; transitionsing to end-of-life  Information Required with Referral |   |  |  |  |  |  |  |  |
| Medications and Doses Consultations and Recent Cl  | nical Notes Laboratory and Diagnostic Imaging |  |  |  |  |  |  |  |
| MD OHIP Billing number:  |   |  |  |  |  |  |  |  |
| Referring MD Name: P   | hone Number: Fax Number:                      |  |  |  |  |  |  |  |
| MD Signature: Date:  |   |  |  |  |  |  |  |  |
| For Office   | Use Only                                      |  |  |  |  |  |  |  |
| Appointment Date: Appointment Time:  | MD Name:                                      |  |  |  |  |  |  |  |
| Appointment Given To: Patient Other:   |   |  |  |  |  |  |  |  |
| Date Notified: Date Received:  Page 1 of 2 - Form Number 9822 D HR (May/2021)  | Staff Signature:                              |  |  |  |  |  |  |  |



## THP PALLIATIVE CARE AMBULATORY REFERRAL FORM

Telephone Number: 905-813-1100 extension 5143

Fax Number: 905-813-4024

| Account Number:    |  |  |  |
|--------------------|--|--|--|
| Patient Name:      |  |  |  |
| Date of Birth:     |  |  |  |
| Gender:            |  |  |  |
| Healthcard Number: |  |  |  |
| Unit Number:       |  |  |  |

### **Referral To THP Palliative Care Ambulatory Team**

#### Please note:

- 1. All patients must consent to referral to our program.
- 2. A Diagnosis, Reason for referral, Palliative Performance Scale and Prognosis must be provided for all patients to ensure timely, efficient and effective navigation.
- 3. Referrals must be accompanied by appropriate clinical information including consultations and clinical notes, laboratory and diagnostic information and medications with dosages.
- 4. If prognosis is less than one year and the patient has a functional decline please initiate a referral to the LHIN Palliative Care Homecare Services.

Any patient with a life threatening illness may be referred to the Palliative Care Team at Trillium Health Partners. Referrals will be triaged to the most appropriate provider based on geography, complexity and assessed needs.

Our team may advise on and refer to appropriate resources beyond our team, and/or provide a one-time consult, or ongoing care based on the above criteria. Care may be provided virtually, in clinic or by a home visit depending on patient care needs.



# Palliative Performance Scale (PPSv2) version 2

| PPS<br>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<br>Some evidence of disease | Full                            | Normal or reduced | Full                            |
| 70%          | Reduced              | Unable to do Normal Job/Work<br>Significant disease            | Full                            | Normal or reduced | Full                            |
| 60%          | Reduced              | Unable to do hobby/house work<br>Significant disease           | Occasional assistance necessary | Normal or reduced | Full or Confusion               |
| 50%          | Mainly Sit/Lie       | Unable to do any work<br>Extensive disease                     | Considerable assistance reqired | Normal or reduced | Full 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<br>Bound | Unable to do any activity<br>Extensive disease                 | Total Care                      | Normal or reduced | Full or Drowsy<br>+/- Confusion |
| 20%          | Totally Bed<br>Bound | Unable to do any activity<br>Extensive disease                 | Total Care                      | Minimal to sips   | Full or Drowsy<br>+/- Confusion |
| 10%          | Totally Bed<br>Bound | Unable to do activity<br>Extensive disease                     | Total Care                      | Mouth care only   | Drowsy or Coma<br>+/- Confusion |
| 0%           | Death                | -  | -                               | -                 | -                               |