PATH Palliative and Transitional Health Care at Home

*Journeys are better when we do them together*

# PATH Physician Referral Form

**To avoid a delay in our response to your request, please complete all sections of this form & include the following information:**

☐ Relevant admission, consult & discharge notes ☐ Imaging reports ☐ Recent laboratory results

**We will strive to see patients within 1-2 weeks. If your patient needs to be prioritized, please contact us to review the situation at: (647)xxx-xxxx**

## PATIENT INFORMATION

Last name: _____ First name: _____

Birth date (DD MM YYYY):_____

Health card number: _____ Version code: _____

Sex: _____ Gender Identity (if known): _____ Preferred Pronouns (if known): _____

Home address: _____ Apt: _____ Entry code: _____ Postal code: _____

Home phone: _____ Cell phone: _____

Primary language: _____ Translator's name: _____ Phone: _____

**Current location:** ☐ Home ☐ Hospital/PCU: _____ Anticipated discharge date: _____

## OTHER CONTACT INFORMATION

Primary contact

| Name | Relationship | Home phone | Cell phone |
|---|---|---|---|
| | | | |

Alternate contact(s)

| Name | Relationship | Home phone | Cell phone |
|---|---|---|---|
| | | | |

## MEDICAL INFORMATION

**Primary reason for referral**
☐ End-of-life care ☐ Symptom management ☐ Other: _____

**Primary palliative diagnosis:** _____ **Date of diagnosis:** _____

Other relevant diagnoses/comorbidities: _____

**Individual aware of:** Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

**Family aware of:** Diagnosis: ☐ Yes ☐ No Prognosis: ☐ Yes ☐ No Does not wish to know: ☐ Yes ☐ No

**Anticipated prognosis:** ☐ < 1 month ☐ < 3 months ☐ < 6 months ☐ < 12 months ☐ uncertain

**Determined by (name and phone number):** _____

**Functional status:** ☐ Able to get out to appointments ☐ Confined to house ☐ Confined to bed

**DNR:** ☐ Yes ☐ No ☐ Unknown

**Is this patient actively waiting for a palliative care unit bed?** ☐ Yes ☐ No

**Infection control:** ☐ MRSA / VRE / ESBL

**Patient / Family key issues & concerns (e.g. domestic violence, substance abuse, translator required)**

## FAMILY PHYSICIAN INFORMATION

Name: _____ Phone: _____ Fax: _____

Family physician aware of referral request ☐ Yes ☐ No

## REFERRAL SOURCE INFORMATION – must be complete before a referral will be accepted

Individual completing form (please print): _____ Phone: _____ Fax: _____

Referring physician or NP (please print): _____ Phone: _____ Fax: _____

Referring physician's or NP's billing number: _____ Date of referral :( DD/MM/YYYY): _____

**Please fax the completed referral form & health records to (647) 689-7284. Thank you for referring to PATH.**