

RESIDENTIAL HOSPICE REFERRAL FORM

Office Use Only

Date Received
File Number

Client Information

SURNAME			Current PPS: <input type="checkbox"/> 50% <input type="checkbox"/> 40% <input type="checkbox"/> 30% <input type="checkbox"/> 20% <input type="checkbox"/> 10% <input type="checkbox"/> Greater than 50% Urgency: <input type="checkbox"/> < 24 hours <input type="checkbox"/> 1-2 business days <input type="checkbox"/> < 1 week <input type="checkbox"/> 1-2 week <input type="checkbox"/> > 2 week <input type="checkbox"/> Future admission Signed DNR-C form: <input type="checkbox"/> Yes <input type="checkbox"/> No Prognosis: <input type="checkbox"/> < 1 week <input type="checkbox"/> < 1 months <input type="checkbox"/> < 3 months <input type="checkbox"/> > 3 months
FIRST NAME	Preferred name		
HEALTH CARD NUMBER	Version		
DOB (MMM/DD/YYYY)	Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: _____	
ADDRESS	Postal Code		
PHONE NUMBER	Home	Cell. #	
Primary Contact Person Relationship: _____	Name	Tel. #	
	Email Address: _____		
Able to speak English?	<input type="checkbox"/> Yes <input type="checkbox"/> No; Primary language is _____		
Current Care Service	<input type="checkbox"/> CELHIN Home Care <input type="checkbox"/> Scarborough Health Network (SHN) <input type="checkbox"/> SCHC Palliative Care Community Team (PCCT) <input type="checkbox"/> Hospital, _____ <input type="checkbox"/> Long Term Care, _____ <input type="checkbox"/> GP, Dr. _____ <input type="checkbox"/> Other, specify: _____		

Diagnosis Information

Diagnosis	Mets (if cancer) to:	When diagnosed (MM/YY)
Co-Morbidities		
Awareness	Individual aware of diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> Does not wish to know Family aware of diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> Does not wish to know	
Current Care Needs	<input type="checkbox"/> Hydration: <input type="checkbox"/> SC <input type="checkbox"/> IV <input type="checkbox"/> Feeding tube <input type="checkbox"/> Central Line <input type="checkbox"/> Port-A-Cath <input type="checkbox"/> PICC line <input type="checkbox"/> Oxygen <input type="checkbox"/> Infusion pump <input type="checkbox"/> CADD pump, Medication: <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Tracheostomy <input type="checkbox"/> PleruX catheter <input type="checkbox"/> Tenckhoff catheter <input type="checkbox"/> Pressure Sore, location & stage: _____ <input type="checkbox"/> Wound Care, specify: <input type="checkbox"/> Other Needs: _____	
Current Symptoms	<input type="checkbox"/> Pain, location: _____ <input type="checkbox"/> Delirium <input type="checkbox"/> Infection <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> GI symptoms: _____	
Special Needs	<input type="checkbox"/> MRSA/VRE (+) <input type="checkbox"/> C-Diff (+) <input type="checkbox"/> COVID-19 <input type="checkbox"/> Respiratory infection <input type="checkbox"/> Others, specify precaution: _____	

Referral Source

Referring Clinician	Name & Discipline	Tel. #	Fax #
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Social Worker <input type="checkbox"/> LHIN Care Coordinator			
	CPSO#/CNO#	OHIP #	Date of submission
Referral Checklist (Attach all supportive documents)		Additional Supporting Information	
<input type="checkbox"/> Recent consultation notes <input type="checkbox"/> Current medication list <input type="checkbox"/> Recent laboratory results <input type="checkbox"/> Recent diagnostic imaging reports <input type="checkbox"/> Infection control management (within 2 weeks) <input type="checkbox"/> Specific care protocols e.g. wound care, drain care			

Please fax the referral form with the supportive documents to: **647-797-2276**

Questions? Please call Yee Hong Hospice: 416-412-4571 Ext. 5310 or email us at Hospice@yeehong.com

Admission Criteria

Residential care is provided to individuals who are 16 years and older and meet the following criteria:

- Adults (16 years and older) with any life limiting illness who have elected a residential palliative hospice as their desired care setting
- Prognosis of less than one (1) month and Palliative Performance Scale (PPS) of 30% or less
- Symptoms are manageable by the residential hospice
- Individual is non-bariatric
- Individual is unable to manage and remain at home (either lives alone without informal support or Individual has informal support but care needs exceed the ability of the support team)
- Recognize that restorative care and resuscitation is not a service we provide,
- Understand that no extensive diagnostics or treatments are offered other than those required for symptom and pain management and comfort measures, and
- Live in or have family members who live in Scarborough or in the Eastern Greater Toronto Area
- Have a designated Power of Attorney for Personal Care (POA) or a Substitute Decision Maker (SDM)
- Have a Do Not Resuscitate form (DNR) completed
- Individuals must possess a valid Ontario health card, or coverage under the Interim Federal Health Plan or Treaty status (First Nations people)
- Have a valid COVID-19 test result available prior to the admission
- Exceptions to these criteria will be assessed on a case by case basis and in collaboration with other services according to need and bed availability

Palliative Performance Scale (PPSv2)

version 2

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 Extensive 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 Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-