|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DATE OF REFERRAL (yyyy/mm/dd): | | | | | | | |
| PATIENT INFORMATION | | | | | | | |
| Surname |  | | | | Mobile |  | |
| First name |  | | | | Home |  | |
| Date of Birth (yyyy/mm/dd) |  | | | | | | |
| Address |  | | | | | | |
| Health Card Number |  | | | | | | |
| Primary Care Provider |  | | | | | | |
| Primary Care Provider Phone Number |  | | | | | | |
| SUBSTITUTE DECISION MAKER IF KNOWN | | | | | | | |
| Name |  | | | | | | |
| Relationship |  | | | | | | |
| Contact Number |  | | | | | | |
| CLINICAL INDICATION | | | | | | | |
| Urgency |  Urgent (Within 3 days) **Must call 613-548-2485 to discuss with consultant** | | | | | | |
|  Routine | | | | | | |
| Select consult service |  | Palliative Care Clinic at the Cancer Centre of South Eastern Ontario | | | | | |
|  | Belleville General Hospital Satellite Palliative Clinic (for patients with cancer) | | | | | |
|  | Regional Treatment Centre (Correctional Services Canada) | | | | | |
|  | Community Palliative Consult Team (patients to be seen in their homes) | | | | | |
| REASON FOR REFERRAL | | | | | | | |
| Palliative Diagnosis |  | | | | | | |
| Details (Include specific symptoms) |  | | | | | | |
| Current Medications and/or Treatments |  | | | | | | |
| ADDITIONAL PATIENT INFORMATION | | | | | | | |
| Patient is aware of the referral | | |  No  Yes | | | | |
| Patient requires a translator | | |  No  Yes | If ***yes***, indicate Language | | |  |
| Patient has been seen or followed by Palliative Care before | | | | | |  No  Yes | |
| Palliative Performance Score (PPS)**Required**: See table below for scoring table  10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ 100 ☐ | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **PPS**  **Level** | **Ambulation** | **Activity Level & Evidence of Disease** | **Self -care** | **Intake** | **Conscious Level** |
| **PPS 100%** | Full | Normal activity and work  **No evidence** of disease | Full | Normal | Full |
| **PPS 90%** | Full | Normal activity and work  **Some evidence** of disease | Full | Normal | Full |
| **PPS 80%** | Full | Normal activity and work *with*  effort  **Some evidence** of disease | Full | Normal or reduced | Full |
| **PPS 70%** | Reduced | Unable normal activity and work  **Significant** disease | Full | Normal or reduced | Full |
| **PPS 60%** | Reduced | Unable hobby/housework  **Significant** disease | Occasional assistance | Normal or reduced | Full or confusion |
| **PPS 50%** | Mainly sit/lie | Unable to do any work  **Extensive** disease | Considerable assistance | Normal or reduced | Full or drowsy or confusion |
| **PPS 40%** | Mainly in bed | Unable to do most activity  **Extensive** disease | Mainly assistance | Normal or reduced | Full or drowsy  +/- confusion |
| **PPS 30%** | Totally bed bound | Unable to do any activity  **Extensive** disease | Total care | Reduced | Full or drowsy  +/- confusion |
| **PPS 20%** | Totally bed bound | Unable to do any activity  **Extensive** disease | Total care | Minimal sips | Full or drowsy  +/- confusion |
| **PPS 10%** | Totally bed bound | Unable to do any activity  **Extensive** disease | Total care | Mouth care only | Drowsy or coma |
| **PPS 0%** | Dead |  |  |  |  |
| **Instructions:** PPS level is determined by reading left to right to find a ‘best horizontal fit.’  Begin at left column reading downwards until current ambulation is determined. Then, read across to next column and downwards until each column is determined. Thus, ‘leftward’ columns take precedence over ‘rightward’ columns. | | | | | |

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| REFERRING CLINICIAN INFORMATION | |
| Include the following information in the space provided to the right:  Site Name  Phone  Fax  Address  City  Province  Postal Code  Billing Number  Professional ID  Clinician Type |  |
| Signature |  |
| Printed Name |  |
| Designation |  |
| Date (yyyy/mm/dd), Time (hhmm) |  |
| Copy of referral and / or  status updates to be sent to: |  |