

## RESIDENTIAL HOSPICE REFERRAL FORM

**Office Use Only**

Date Received  
File Number

### Client Information

<b>SURNAME</b>			<b>Current PPS:</b> <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% <b>Urgency:</b> <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 <b>Signed DNR-C form:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Prognosis:</b> <input type="checkbox"/> < 1 week <input type="checkbox"/> < 1 months <input type="checkbox"/> < 3 months <input type="checkbox"/> > 3 months
<b>FIRST NAME</b>	Preferred name		
<b>HEALTH CARD NUMBER</b>	Version		
<b>DOB (MMM/DD/YYYY)</b>	<b>Gender</b>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: _____	
<b>ADDRESS</b>	Postal Code		
<b>PHONE NUMBER</b>	Home	Cell. #	
<b>Primary Contact Person Relationship:</b> _____	Name	Tel. #	
	Email Address: _____		
<b>Able to speak English?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No; Primary language is _____		
<b>Current Care Service</b>	<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

<b>Diagnosis</b>	Mets (if cancer) to:	When diagnosed (MM/YY)
<b>Co-Morbidities</b>		
<b>Awareness</b>	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	
<b>Current Care Needs</b>	<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: _____	
<b>Current Symptoms</b>	<input type="checkbox"/> Pain, location: _____ <input type="checkbox"/> On CADD pump: <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> GI symptoms: _____ <input type="checkbox"/> Delirium <input type="checkbox"/> Infection	
<b>Special Needs</b>	<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

<b>Referring Clinician</b>	<b>Name &amp; Discipline</b>	<b>Tel. #</b>	<b>Fax #</b>
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Social Worker <input type="checkbox"/> LHIN Care Coordinator			
	<b>CPSO#/CNO#</b>	<b>OHIP #</b>	<b>Date of submission</b>

<b>Referral Checklist (Attach all supportive documents)</b> <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	<b>Additional Supporting Information</b>     
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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](mailto: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*

<b>PPS Level</b>	<b>Ambulation</b>	<b>Activity &amp; Evidence of Disease</b>	<b>Self-Care</b>	<b>Intake</b>	<b>Conscious Level</b>
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	-	-	-	-