RESIDENTIAL HOSPICE REFERRAL FORM

Office Use Only
Date Received
File Number

Client Information

SURNAME		
FIRST NAME	**Preferred name**	
HEALTH CARD NUMBER	**Version**	
DOB (DD/MM/YYYY)		**Gender** ☐ M ☐ F ☐ Other: ________
ADDRESS	**Postal Code**	
PHONE NUMBER	Home	Cell. #
Primary Contact Person Relationship:	Name Email Address:	Tel. #
Able to speak English?	☐ Yes ☐ No; Primary language is ______________________	
Current Care Service	☐ CELHIN Home Care ☐ Scarborough Health Network (SHN) ☐ SCHC Palliative Care Community Team (PCCT) ☐ Hospital, ______________ ☐ Long Term Care, ________________ ☐ GP, Dr. ______________ ☐ Other, specify:	

Current PPS:
☐ 50% ☐ 40% ☐ 30%
☐ 20% ☐ 10%
☐ Greater than 50%

Urgency:
☐ < 24 hours
☐ 1-2 business days
☐ < 1 week
☐ 1-2 week
☐ > 2 week
☐ Future admission

Signed DNR-C form:
☐ Yes ☐ No

Prognosis:
☐ < 1 week
☐ < 1 months
☐ < 3 months
☐ > 3 months

Diagnosis Information

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

Referral Source

Referring Clinician ☐Physician ☐Nurse Practitioner	**Name & Discipline** **CPSO#/CNO#**	**Tel. #** **Billing #**	**Fax #** **Date of submission**

Referral Checklist (Attach all supportive documents)
☐ Recent consultation notes
☐ Current medication list
☐ Recent laboratory results
☐ Recent diagnostic imaging reports
☐ Infection control management (within 2 weeks)
☐ Specific care protocols e.g. wound care, drain care

Additional Supporting Information

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 three (3) months 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 *with* 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	-	-	-	-