

A Palliative Approach to Care REFERRAL FORM

Date & time:		Health Card Number:	
Person referring:		Contact Person:	
		Relationship:	
Patient:		Contact's phone #:	
Address/Facility:		DOB:	
City:		Phone:	
MRP:		PC MD:	

- Consent for consult
 HCC involved
 Paediatric
 Oncology RVH or elsewhere _____

Reason for referral:

- Need family physician for home visits
 Hospice Palliative Nurse Consultant Involvement
 Need for NP for home visits

Main Concern of Patient/Family (note if different):

Diagnosis (include co-morbidities)	PPS & Date completed		DNR:	Yes or No
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Comments:

FAX completed referral form to NSMHPCN 705-325-7328
If request is URGENT please also call 705-325-0505

Interventions/Recommendations:

Follow-up/ Communication to & date:

- MRP _____
 Palliative Resource Physician _____
 HCC _____
 Nursing Agency _____
 Other _____