

Palliative Pain and Symptom Management Consultation with **Service Provider**

Consultation with SERVICE PROVIDERS to mentor and guide the application of best practice tools and guidelines in Hospice Palliative Care. Responsibility for client/patient assessments will remain with the service provider; guidance on the process and application of such assessments will be taught by the PPSMC with the opportunity to build capacity through joint visits with patients, virtual conferencing and conversation.

Health Care Provider Making Referral

First Name:		Last Name:	
Preferred Date to Contact:		Preferred Time to Contact:	<input type="checkbox"/> AM <input type="checkbox"/> PM
Job Title:			
Organization Name:			
City/Area:			
Phone Number :		Extension:	
Email Address:			

Patient/Resident Information:

First Name:		Last Name:	
Date of Birth:		Age:	
Allergies:		Does the Patient Self-Identify as FNIM?	Yes No
		If yes, please specify:	First Nations Inuit Métis Other
Name of Most Responsible Physician (MRP) and/or NP Involved:			

Situation:

In your opinion, would you be surprised if the patient were to die in the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient receiving a palliative approach to care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Appropriate for any individual and their families who are facing issues associated with life-limiting illness to improve their quality of life at any stage.

Brief description of situation/concerns:

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Background:

Diagnose(s) (life-limiting conditions) and relevant medical history:

PPS Score:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Has there been a recent change in PPS? Yes No

Presenting Symptom(s)/Issues:

<input type="checkbox"/> Pain	
<input type="checkbox"/> Other Symptom:	
<input type="checkbox"/> Other Concern (i.e. family care conference):	

Assessment:

Relevant Medications for Symptom Control (please enter relevant medications for pain and/or symptom management below)

Medication	Dosage	Route	Times Given

Additional information to aid in the the case based discussion with the Palliative Pain and Symptom Management Consultant (PPSMC):

Goals of this palliative care nursing consultation (PPSMC) being requested:

FAX completed referral form to NSMHPCN at 705-325-7328
 If you wish to speak to to speak to a
Palliative Pain and Symptom Management Consultant
 directly please call 705-325-0505