nova

SOINS À DOMICILE ✦ HOME CARE

Reference | Palliative Care / In-Home Respite Program

Requested by

Department

Phone

Surname

Name

Date of Birth

Gender M ☐ F ☐ Other ☐ :

Medicare

Address

City

Postal Code

Support System (other than caregiver)

Name of family or significant person

Cell

Home

Office

Caregiver

Name

Age Language

Number of hours per week

Cell

Home

Office

Reason for request

Primary diagnosis: (date)

Infectious disease: (specific precautions)

Related diagnosis:/ services received (dates)

Medications

Allergies

Medical follow-up

Telephone

Fax

Pager

Hospital / Address

CLSC / Other Implicated

Telephone

Fax

Pager

CLSC / Other Implicated

Telephone

Fax

Pager

Physical Abilities / Incapacity

Inability: ☐ Mobility ☐ Behaviour ☐ Incontinence

☐ Communication ☐ Mental Status ☐ Motivation

☐ Identify Hazards ☐ Management of medication

Other relevant issues

Supplies / equipment

Others professionals implicated

Name

Profession

Telephone

Name

Profession

Telephone

Situation/ Family Support Issues

Specifics

Description of the network support and services
(neighbours, organizations)

Other information i.e. references in progress,
pre-admission in palliative care

Consent for reference and transmission information

☐ Agree ☐ Disagree

Financial capacity: approximate annual household income

☐ Less than $25,000 ☐ $25,000 - $40,000 ☐ More than $40,000

Comments

Date

Name

Signature