**Reference** |

 Palliative Care

Requested by Department Phone



Surname Name

Date of Birth

Gender M F Other : Medicare

# Support System (other than caregiver)

Name of family or significant person

Cell Home Office

Reason for request

Primary diagnosis: (date)

Infectious disease: (specific precautions)

Related diagnosis:/ services received (dates)

Address

City

Postal Code

# Caregiver

Name

Age Language

Number of hours per week Cell

Home Office

Medications

Allergies

Medical follow-up

Telephone Fax

Pager

Hospital / Address

CLSC / Other Implicated

Telephone Fax

Pager

CLSC / Other Implicated

# Situation/ Family Support Issues

Specifics

Description of the network support and services

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

(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