Referral Form – Rotary Hospice House and Home Hospice

Patient

Last Name: ______________________________ First Name: _________________ DOB: ________________ Age: _____
Present Location: ____________________________________ Gender Pronouns: ________________ Sex: ______________
Provincial Health # (PHN): _____________________________

Referral

Date of Referral: ______________________
Type: ☐ Home Hospice –EOL *must have a live in caregiver and a 1 month estimated prognosis
☐ Rotary Hospice House-EOL ☐ RHH-Symptom Mgmt ☐ RHH-Respite ☐ RHH-Transition Support
If not EOL or PPS > 20% , what is plan for d/c? __________________________________ family and Dr. agree? Yes/No

MD

Family Doctor (MRP) _________________________ Doctor for Orders (if not MRP): ______________________

Diagnosis

PPS: _____
Allergies: ____
Diagnosis: ____
Comorbidities: ____

Est. Prognosis
☐ Imminent
☐ 3-6 Weeks
☐ 3-6 Months
☐ Unsure
Urgency:

Contact

Person Making Referral: ________________________________ Rltship: _________________ Phone: __________________
SDM: ____ Rltship:_________________ Phone: __________________
Executor/Next of Kin: __________________________________ Rltship: _________________ Phone:__________________
Contact (If different than SDM): _________________________ Rltship: _________________ Phone: __________________
Aware of Referral: Patient: ☐ Yes ☐ No Family: ☐ Yes ☐ No Physician: ☐ Yes ☐ No
Patient has a physician willing to follow, prior to admission ☐ Yes
(We cannot accept patient unless referring or family physician in agreement to continue responsibility of patient while at hospice)
Guest/Family Aware of Fees: ☐ Yes ☐ No If no, advised referring professional to inform guest/family or fees? ☐ Yes

Required Forms

Admission Paperwork	Yes	No
Northern Health Palliative Program	☐	☐
DNR/AND	☐	☐
If MOST filled out, M1 or M2	☐	☐
On Home Nursing Program	☐	☐
BC Palliative Care Benefits Program	☐	☐
Care Facility Admission Consent (RHH only)	☐	☐

Infectious Screen

Infectious Precautions ☐ ☐
____
____
____

Notes

CHANGES NOTED IN LAST 2 WEEKS – PLEASE IDENTIFY:
Confusion, Level of Consciousness, Ambulation, Physical Symptoms, Emotional Stressors, Family Stressors

Wound care/dressings? Yes/No _________________________
Any Lines/Tubes? Yes/No ______________________________
Any violence/aggression? Yes/No
If yes, explain: _______________________________________

List of Paperwork received before accepting admission:

MARS	☐
Med Hx	☐
Consults	☐
Demographics	☐
Last 4 days of Nursing Notes	☐
Recent bloodwork	☐

	Yes	No	
O_2 Requirement	☐	☐	____L/min via________
Uses CPAP?	☐	☐	
Any curative treatment?	☐	☐	__________________
(Currative treatment prevents EOL admission)			
Bariatric Bed Required	☐	☐	
Chemotherapy & Last Date	☐	☐	__________________
Internal Defibrillator	☐	☐	
Pace Maker	☐	☐	
Wait List/Reason	☐	☐	__________________
Not appropriate/Reason	☐	☐	__________________