Hospice Referral Form

Priority ☐**A** Crisis Intervention ☐**C** Moderate Risk ☐**B** High Risk ☐**D** Minimal to No Risk

Date: _____

Request Admission to ***All fields required***

	McNally House	Niagara	Carpenter	Bob Kemp	Stedman
	McNally☐	Niagara☐	Carpenter☐	Bob Kemp☐	Stedman☐
Fax to➔	**905-309-6656**	**905-646-3860**	**905-631-7107**	**905-387-7822**	**519-751-7527**

Bereavement Service☐ Day Program☐ Outreach Team☐ Residential Bed☐ Volunteer Visiting☐

Name: _____

Home Address: _____
Street *City/Province* *Postal Code*

Telephone: _____ Client's Present Location: _____

Date of Birth: _____ Gender: M☐ F☐ Allergies: _____
yy/mm/dd

Family Physician/MRP: _____ Phone: _____ Fax: _____

Specialist: _____ Phone: _____ Fax: _____

Health Card #: _____ VC: _____ BRN: _____

Pharmacy: _____ Phone: _____

Next of Kin/Contact Person

Name: _____ Relationship: _____

Address: _____
Street *City/Province* *Postal Code*

Telephone: _____ _____ _____
Home *Work* *Cell*

Power of Attorney for Personal Care

Name: _____ _____ _____ _____
Home *Work* *Cell*

Diagnosis: _____ Date of on-set: _____

PPS: _____

History of: **MRSA** No☐ Yes☐ ?☐ **VRE** No☐ Yes☐ ?☐ **C-Diff** No☐ Yes☐ ?☐

Briefly describe symptoms requiring management (nausea, pain, etc.)

Patient's & family's goals & expectations, including patient's understanding of reason for admission.

DNR Yes☐ No☐

Attachments History☐ Consult Notes☐ Progress Notes☐ Medication Record☐ Pertinent Diagnostic Tests☐ Care Plan☐

Referral Source Facility: _____ Phone: _____
Contact Person: Phone:

Eligibility for Hospice Services Confirmed by: _____ _____
Signature *Date*