Heart House Hospice Referral Form

Referral can be made by calling 905-712-8119 (msg. can be left on general voice mail), by fax 905-712-4029 or by email @ info@hearthousehospice.com

❑ **REFERRAL** ❑ **CONSULT**

For Hospice Use only

Received Date: ____________________

Taken By: ____________________ ❑Tel. ❑ V.M.

Entered Date: ____________________

Date Received by HCC: ____________________

Care Coordinator: ____________________

Client ID#:

Intersection: ____________________

Client name: ____________________ ❑M ❑F

Street: ____________________ Apt: __________

City: ❑Miss. ❑Bram. ❑Malton Postal Code: __________

Phone #: ____________________ Cell: ____________________

Birth Date: ____________________ Age: __________

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Common law

Preferred Language: ____________________

Email (Client): ____________________

Referral Source:

Name: ____________________

Organization: ❑Trillium ❑CVH ❑ BCH ❑IAH ❑CCAC-CW ❑CCAC-MH ❑Other ____________________

Phone #: ____________________

Email: ____________________

Health Card #:

Primary Hospital: ____________________ Physicians: ____________________ PPS%: __________

Next of Kin Information

NOK ID#: __________ Name: ____________________ Relationship: ____________________

Tel. __________ (Home) __________ (Cell) __________ (Work) Email: ____________________

Address: (if different from client's): ____________________

NOK Id. # __________ Name: ____________________ Relationship: ____________________

Tel. __________ (Home) __________ (Cell) __________ (Work) Email: ____________________

Address: (if different from client's): ____________________

Person to contact to discuss hospice:

Diagnosis: ____________________

Anticipated prognosis: ❑<1month ❑<3months ❑<6months ❑<12 months ❑Uncertain **DNR:** ☐ Yes ☐ No

Patient aware of: Diagnosis ☐ Yes ☐ No Prognosis ☐Yes ☐No ☐Does not wish to know

Family aware of: Diagnosis ☐ Yes ☐ No Prognosis ☐Yes ☐No ☐Does not wish to know

Have end-of-life issues been discussed with patient? ☐ Yes ☐ No

Reason for referral:

☐ Consult ☐ Information ☐ Volunteer ☐ Spiritual Support ☐Caregiver Support/Respite ☐ Future Bereavement

Other: ____________________

Urgency of response: ☐ Within 2 days ☐ Within 1 week ☐ Within 2 weeks

Referral made to: ❑CCAC ❑ IAH ❑ DLH ❑ Tor. Grace ❑ Bethel **CCAC Case Manager:** ____________________

Support Services: ❑ Nursing __________________ ❑ PSW____________________ ❑ OT/PT ❑ Social Work

Other information: ____________________