REFERRAL FOR MARIANHILL HOSPICE
https://marianhill.ca/services/hospice-palliative-care/

Please FAX completed form to:
613-732-3934

Attention: Diane Tennant DOC

Admission request:
- ☐ Immediate
- ☐ Future
- ☐ Pain and symptom management
- ☐ Respite

Referral Principles

Completion of this referral is a request for an admission to the Marianhill Hospice. Future or back-up referrals will be accepted.
Patients referred to Marianhill Hospice are triaged based on established criteria into the most appropriate care setting. To ensure sufficient and accurate information is available as part of the referral package, the expectation is referred patients will have had an assessment by one of the following partners:

- Palliative Pain and Symptom Management Consultation Service
- Hospitals
- Champlain Hospice Palliative Community Network, Community Palliative Care Physicians/Home & Community Support Services

Champlain Care Case Managers
Please ensure a copy of the consult note is included in the referral package ☐ ***Yes, Copy attached.***

I have informed the patient and/or the patient's substitute decision maker about the purpose for the collection of the information in this application which will be used to assist in determining admission to Marianhill Hospice based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Director of Care Marianhill Hospice (600 Cecelia Street Pembroke, ON K8A 7Z3). Consent to Admission to Marianhill Hospice has been complete.

☐ ***Yes, I have completed this task.*** **Referral Completed by:** ______________________________________
Telephone: ______________________________________
Pager or Cell Phone: ______________________________________

Patient Demographics

Given name: ______________________________________ Surname: _______________________________

Sex: ☐ Male ☐ Female Date of birth (dd/mm/yyyy): _____________ Home Phone: _______________________

Address: ______________________________________ City: ______________________________

Province: ____________ Postal Code: ____________

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other: ___________

Preferred language: ☐ French ☐ English ☐ Other: __________________

Health Card #: ____________________________ Version Code: _____________ Expiry Date: ___________________

Reason for Referral

☐ End of Life Care - EOL (last days to weeks) ☐ Patient or family do not wish home death ☐ Symptom management and EOL care.

☐ Symptom management with potential discharge ☐ Respite

☐ Other (details) ____

Marianhill Hospice Services

Acute Palliative Pain and Symptom Management or Respite Admission (depending on bed availability): Short Stay & Symptom Control	For the very end of life: last days or weeks of life
• Patients have a non-curable, progressive, life-threatening disease. • Require daily symptom management by specialist physician & team. • Presence of persistent pain or other complex/difficult symptom, Edmonton Symptom Assessment System (ESAS) ≥ 4/10 • PPS not a criteria • Valid OHIP number	• Patients have non-curable, progressive life-threatening disease with a prognosis of less than 3 months • Patients are not on curative therapy. • PPS equal or less than 40% • DNR order in place • Valid OHIP number • Resident aware that hospice does not provide MAID

Discharge Criteria

Patients who no longer meet the admission criteria will be considered for discharge when:

The intensity and clinical expertise of the program is no longer required.
The patient's functional status stabilizes or improves to such a degree that life expectancy exceeds just a few days or weeks.
They and their families express the wish to return home.
Their care needs can be met at home or elsewhere.
They require a level of pain and symptom management more complex than that available at the Hospice.
Patient POA aware of Discharge Criteria ☐ Yes

Referral Information

Patient's Current Location: ____________________ Date of Referral Completion: ______________________

Home & Community Care Support Services Champlain involvement: ☐Yes ☐No Case Manager: ____________________
Pager/Cell: ___________________

Referral Completed by: _________________________________ Tel. __________________ Pager: _______________

Pharmacy in the Community: ____

Patient's Contact Information

First Contact: ______________________________ Relationship: ________________ Tel. ____________________

Substitute Decision Maker (personal care) __________________ Relationship: _____________ Tel. _____________

Power of Attorney for Property _______________________ Relationship: _____________ Tel. _____________

Attending Physician (full name) _____________________ Tel. __________________ Pager/Cell: _______________

Referring Physician (full name)_____________________ Tel. __________________ Pager/Cell: _______________

Family Physician (full name) _______________________ Tel. __________________ Pager/Cell: _______________

Medical information

Main Diagnosis: ____

- Date of diagnosis (Month/year) ____
- If cancer, metastatic sites ____
- Summary of treatments (chemo, radiation, dialysis) ____

  ____
- Noteworthy complications (i.e. spinal cord compression) ____

  ____

Other Concurrent Illnesses ____

____

____

Noteworthy Past Medical History: ____

____

Allergies ____

____

Current weight: ____________________________________
Infections: ☐ Yes ☐ No
☐ MRSA+ ☐ VRE+ ☐ C-diff ☐ Outbreak unit ☐ Other ____________________________________
Details of precautions in place _____________________________________

- ✓ **A medical discharge summary must accompany the patient at the time of admission.**
- ✓ **It is imperative to include a copy of the Current Medication Administration Record (MAR),**
- ✓ **5 days of progress notes and the medical admission history and physical with the application.**
- ✓ **Reference Source must initiate Home & Community Care Support Services Champlain referral prior to admission to Marianhill Hospice**
- ✓ **When coming from TOH/QCH or other site that has palliative care consultations – consultation notes must be included.**

Psychosocial Situation

☐ Patient and/or family coping difficulties ☐ Patient lives alone ☐ Caregiver stress, illness ☐ Family tension

☐ Substance abuse ☐ Psychiatric issues ☐ Behavioural issues ☐ Cognitive deficit (dementia/delirium) ☐ Social isolation.

Comments (provide details):
____

____

____

Goals of Care and Advance Care Planning (Do Not Resuscitate and Medical Assistance in Dying) (select all that apply)

➢ SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

Describe Goals of Care: ____

DNR Order in place: ☐ Yes ☐ No
If yes, please select:
☐ DNR Discussed and Confirmed with Patient/SDM
Date of most recent discussion (dd/mm/yyyy): _______________

If no please discuss with patient and obtain DNR order
DNR Order Obtained ☐ Yes.
Date of DNR Order obtained (dd/mm/yyyy): _______________
***Patients will be required to sign admission agreement and specific form acknowledging that Marianhill Hospice does not provide CPR.**

➢ SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION
Marianhill Hospice does not permit the provision of Medical Assistance in Dying ("MAID"). Authorization for admission to Marianhill Hospice must be signed and completed by the capable applicant.

Capable applicants will be required to sign Authorization for admission to Marianhill Hospice form. acknowledging consent to admit to hospice and that Marianhill Hospice does not provide MAID.

☐ **Completed & attached**

Family Physician and Palliative Care Consultation Team Contact

Has the referring professional contacted a Palliative Care Consult Team? ☐ Yes ☐ No
If yes, I have attached the consult summary ☐ Yes

**Please note that contact from physician to physician may be preferred for admission approval.

Patient Symptom and Needs Profile: Palliative Performance Scale (PPS)						
Check √ Condition	**PPS Level**	**Ambulation**	**Activity & Evidence of Disease**	**Self-Care**	**Intake**	**Conscious Level**
	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
	80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
	60%	Reduced	Unable hobby/housework Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
	50%	Mainly Sit/Lie	Unable to do any work Significant disease	Considerable Assistance required	Normal or reduced	Full or Confusion
	40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
	30%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
	20%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
	10%	Totally Bed Bound	Unable to do any activity Significant disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
	0%	Death				

Symptoms: Edmonton Symptom Assessment Scale (ESAS)

Can the patient complete the ESAS? ☐ yes ☐ no Date Completed: ________________________

If no, what is the reason? ☐ Patient too ill (PPS < 30%) ☐ Language barrier ☐ Cognitively impaired/Delirious

☐ Other: ____

ESAS Scores (please indicate score on the scale of 0 to 10. 0 indicates symptom is absent, while 10 is the highest severity of the problem).

Pain ________ Fatigue ________ Nausea ________ Depression ________ Drowsy ________ Appetite ______

Feeling of wellbeing ________ Shortness of breath ________ Other problem _________ details _____________

Swallowing & Intake

Difficulty swallowing or chewing ☐ yes ☐ no Current diet order: ____

Intake: ☐ Normal ☐ Reduced ☐Sips only ☐ NPO

Equipment Care Needs

IV in Use: ☐ Yes ☐ No Access: ☐ Peripheral ☐ Sub Q

Central Line ☐ Yes ☐ No Type: _____________________________________ Date of last flush: ________________

PICC ☐ Yes ☐ No Type: ____ Number lumens: ________________

CADD Pump ☐ Yes ☐ No Epidural ☐ Yes ☐ No Intrathecal ☐ Yes ☐ No ☐ Other ______________________

Elimination:	**Last Bowel Movement (Date/Time/Quantity):** ___________________________________ **Last Void (Date/Time/Quantity):** ___________________________________

	Foley Catheter: ☐ Yes ☐ No Size/type: ___________ Date inserted: _________

Elimination Device	Supplies required	Date of last change
☐ Colostomy		
☐ Ileostomy		
☐ Nephrostomy		
☐ Ileo-conduit		

Supplemental Oxygen ☐ Yes ☐ No LPM ______ ☐ NP ☐ Mask Other ___________________

BiPAP: ☐Yes ☐No CPAP: ☐Yes ☐No Settings: _______ Frequency: _______ Does patient own mask? ☐Yes ☐No

Tracheostomy: ☐Yes ☐No Size and brand: _______________________________ ☐ Cuffed ☐ Uncuffed

Is the patient suctioned? ☐ Yes ☐ No Type: ______________ Frequency: ______________________

Enteral feeding: ☐ Yes ☐ No Route: ☐ PEG ☐ PEJ ☐ N/G Bolus☐ Continuous☐

Product Used: ______________________ Volume per feed: _________ Hourly Rate: _________ Frequency: _____

Flush ☐Yes ☐No Frequency: _____________ Volume per Flush: _____________

Chest tubes: ☐Yes ☐No ☐ Gravity ☐ PleurX ☐ Continuous ☐ Suction: ________ ☐ Intermittent ______ mmH₂0

Date of last drainage: ________________________ Type of mattress in use: _____________________________

Wound sites	Stage	Type of dressing in use

PRE-ARRANGED FUNERAL/PREFERRED FUNERAL HOME:

____

____

ADDITIONAL INFORMATION:

____

____

ACTIVITES OF DAILY LIVING NURSING FUNCTIONAL ASSESSMENT

AMBULATION/MOBILITY

☐ No Aids Required ☐ Bedridden.
☐ Walker
☐ Wheelchair ☐ Self-propelled ☐ Assisted
☐ Assistance Required ☐ Independent ☐ One Person ☐ Two Person

TRANSFER

☐ Independent ☐ Two Person
☐ Requires Supervision ☐ Mechanical aid.
☐ Requires one person assistance ☐ Cannot weight bear.

BOWEL

☐ Full Control ☐ Occasionally Incontinent
☐ Incontinent ☐ Using Incontinent product Size: ________________________

BLADDER

☐ Full Control ☐ Occasionally Incontinent
☐ Incontinent: ☐ Using incontinent product Size: ________________________

COGNITIVE FUNCTION ☐ Unimpaired ☐ Impaired Judgement ☐ Lacks Attention
☐ Recent Memory Loss ☐ Remote Memory Loss ☐ Forgetful

COMMUNICATION ☐ Adequate ☐ Aphasic/Dysarthric ☐ Communicates with difficulty.
☐ Unable to Communicate (specify): ____

VISION ☐ Adequate ☐ Impaired ☐ Glasses

HEARING ☐ Adequate ☐ Impaired Deaf: ☐ Left ☐ Right ☐ Aids (specify): ________________________

ABILITY TO EAT ☐ Independent ☐ Dependent
☐ Requires Assistance ☐ Set Up ☐ Supervision.
☐ Difficulty Swallowing
☐ Difficulty Chewing
☐ Gastrostomy Tube (specify size and type): ____
Schedule ____

Dentures: ☐ Full ☐ Partial

ABILITY TO DRESS ☐ Independent ☐ Dependent
☐ Requires Assistance (specify): ____

ABILITY TO BATHE OR WASH ☐ Independent ☐ Dependent
☐ Requires Assistance (specify): ______________________________________

MARIANHILL

600 Cecelia Street, Pembroke, Ontario K8A 7Z3 (613) 735-6838 Fax: (613) 732-3934

Authorization for Admission to Marianhill Hospice Palliative Care Unit

To be Completed by the Applicant/SDM

I understand that Marianhill provides Hospice Palliative Care as per their Mission and Values.

I agree to the submission of an application to the Hospice and consent to admission if accepted.

www.marianhill.ca

I agree that should my condition change and I no longer require Hospice care that I will participate in and follow the recommendations of the discharge planning process.

Resident/SDM____________________________

Witness _________________________

Date _________________________________

Medical Assistance in Dying MAID

Marianhill's position on Medical Assistance in Dying (MAID) is aligned with our responsibilities and values as a Catholic Health Care Institution.

If you should request to proceed with MAID, Marianhill will refer to an external provider for information, assessments and provision.