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

**Please FAX completed form to:**
**613-732-3934**

**Attention: Danielle O'Grady**
**Hospice Coordinator**

**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 & Ontario Health at Home 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assist in determining admission to Marianhill Hospice based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Hospice Coordinator Marianhill (600 Cecelia Street Pembroke, ON K8A 7Z3).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.<br>• Require daily symptom management by specialist physician & team.<br>• Presence of persistent pain or other complex/difficult symptom, Edmonton Symptom Assessment System (ESAS) ≥ 4/10<br>• PPS not a criteria<br>• Valid OHIP number | • Patients have non-curable, progressive life-threatening disease with a prognosis of less than 3 months<br>• Patients are not on curative therapy.<br>• PPS equal or less than 40%<br>• Hospice not equipped to provide resuscitation<br>• DNR order in place<br>• Valid OHIP number<br>• 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: _____

Ontario Health at Home 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 (if coming from hospital).**
**5 days of progress notes and the medical admission history and physical with the application.**
**It is imperative to include a copy of the Current Medication Administration Record (MAR).**
**Reference Source must initiate Ontario Health at Home 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): _____

***Patients/SDM will be required to sign admission agreement and acknowledging that Marianhill Hospice is not equipped to provide resuscitation.**

- SECTION MUST BE COMPLETED FOR ADMISSION CONSIDERATION

**Authorization for admission to Marianhill Hospice must be signed and completed by the capable applicant/SDM.**

☐ **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<br>No evidence of disease | Full | Normal | Full |
| | 90% | Full | Normal activity & work<br>Some evidence of disease | Full | Normal | Full |
| | 80% | Full | Normal activity *with* Effort<br>Some evidence of disease | Full | Normal<br>or reduced | Full |
| | 70% | Reduced | Unable Normal Job/Work<br>Significant disease | Full | Normal<br>or reduced | Full |
| | 60% | Reduced | Unable hobby/housework<br>Significant disease | Occasional assistance necessary | Normal<br>or reduced | Full<br>or Confusion |
| | 50% | Mainly Sit/Lie | Unable to do any work<br>Extensive disease | Considerable Assistance required | Normal<br>or reduced | Full<br>or Confusion |
| | 40% | Mainly in Bed | Unable to do most activity<br>Extensive disease | Mainly assistance | Normal<br>or reduced | Full or Drowsy<br>+/- Confusion |
| | 30% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Normal<br>or reduced | Full or Drowsy<br>+/- Confusion |
| | 20% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Minimal to sips | Full or Drowsy<br>+/- Confusion |
| | 10% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Mouth care only | Drowsy or Coma<br>+/- 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):** _____<br>**Last Void (Date/Time/Quantity):** _____<br>**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 _____ $mmH_20$

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** □ Independent □ Dependent
**TO EAT** □ Requires Assistance □ Set Up □ Supervision.
□ Difficulty Swallowing
□ Difficulty Chewing
□ Gastrostomy Tube (specify size and type): _____
Schedule _____
**Dentures:** □ Full □ Partial

**ABILITY** □ Independent □ Dependent
**TO DRESS** □ Requires Assistance (specify): _____

**ABILITY TO** □ Independent □ Dependent
**BATHE OR WASH** □ Requires Assistance (specify): _____

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

Authorization for Admission to Marianhill Hospice

**To be Completed by the Applicant/SDM**

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

I understand that Marianhill Hospice is not equipped to provide resuscitation.

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.

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, continuing to provide palliative care during this process.

**Mission Statement**

Inspired by the healing ministry of Jesus Christ and the life of St. Marguerite D'Youville, Marianhill provides love and compassionate care in the Catholic tradition to older adults within their homes, the community and Marianhill.