



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assist in determining admission to Marianhill Hospice based on the needs of the patient and that their consent can be withdrawn at any time by writing to the Hospice Coordinator Marianhill (600 Cecelia Street Pembroke, ON K8A 7Z3).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

- 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

For the very end of life: last days or weeks of life

- 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%
- Hospice not equipped to provide resuscitation
- 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: _____

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 <input type="checkbox"/> 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 <i>with</i> 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 Extensive 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 Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
	20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
	10%	Totally Bed Bound	Unable to do any activity Extensive 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
<input type="checkbox"/> Colostomy		
<input type="checkbox"/> Ileostomy		
<input type="checkbox"/> Nephrostomy		
<input type="checkbox"/> 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:0
 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:

ACTIVITIES 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): _____



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.

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.