HOSPICE REFERRAL

This Hospice Referral must be completed along with the Continuing Care Facility Referral form.
Fax completed forms to 867-456-6744.

Patient last name	Patient first name	Date of birth YYYY/MM/DD

To be completed by hospice palliative care applicants

Physician information

Referring physician	Family physician

Attending physician for placement (if known or different from above)

Is a palliative care physician* involved?

If yes: Name of palliative care physician: _____

*Note: A palliative care physician is involved in the hospice intake process.

Diagnosis

Palliative performance scale score

☐ 10% ☐ 20% ☐ 30% ☐ 40-50% ☐ 60-100%

Date of diagnosis
YYYY/MM/DD

Primary palliative diagnosis (if not already provided on the Continuing Care Referral form)

Other relevant diagnosis/symptoms

Prognosis

☐ < 1 month ☐ < 3 months ☐ 3-6 months ☐ Greater than 6 months

Additional information

Spiritual/cultural considerations

End of life considerations

Awareness of	Individual	Family
Palliative diagnosis	☐ Yes ☐ No ☐ Does not wish to know	☐ Yes ☐ No ☐ Does not wish to know
Palliative prognosis	☐ Yes ☐ No ☐ Does not wish to know	☐ Yes ☐ No ☐ Does not wish to know

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