- **IF REFERRAL IS URGENT, CONTACT OUR ADMINISTRATIVE ASSISTANT AT**

613-801-0035, ext. 200

- [redacted]ncomplete referrals will be returned without review.
- Care is not assumed until patient is seen by CPMA.
- Fax completed referral to **613-801-0036.**

Criteria for care by our group:

- Must have a life-limiting illness which is actively progressing and requires symptom management and /or end of life care.
- Prognosis has been discussed with patient/POA, who have agreed to referral to CPMA.
- Palliative Performance Scale (PPS) <= 50% (see this resource or cpmaottawa.ca/pps)
- Must have a CCAC Palliative Care Coordinator and be currently receiving palliative home nursing visits. We cannot accept the care of patients who are on a waitlist for nursing services.
- Must have adequate support to be maintained at home, at least initially.
- Must have a signed MD referral **with direct return contact information.**
- Attach most recent consult/clinic notes, relevant imaging reports and recent hospital discharge summary. It is the referring source's responsibility to provide this information to ensure timely consideration.

IMPORTANT NOTES FOR REFERRALS OF HOSPITAL INPATIENTS:

- **New patients are not seen by CPMA on the day of discharge.**
- Ensure a plan for medical care is in place for discharged patients until seen by CPMA. This should be clearly communicated to the patient and caregivers. This is especially important for discharges planned on Fridays, weekends, and holidays.
- **Direct communication between attending team and CPMA physician prior to discharge is mandatory.**
- Inpatient palliative care consultation is strongly recommended.
- **Prior to discharge**, ensure that patient has adequate supplies in place at home. If indicated, order a Symptom Management Kit using the form available at bit.ly/smkchamplain.
- Complex patients should have a nursing visit at home on the day of discharge.
- Request that CCAC transfers patient to the Palliative Care Team upon discharge.
- The discharge summary, including medication list, should be faxed to CPMA at or before discharge.

For details on our coverage area please see our website:
www.cpmaottawa.ca
or the map at bit.ly/ottawapalliativecaremap

Note that if you are using a patient label, please ensure that
the information on the label pertains to the **address where care is to be delivered.**

Section 1: Patient Demographics:

Name:

Gender: Male ☐ Female ☐

Date of Birth:

Health Card # with VC:

Address where care is to be delivered:

Street Address:

City:

Postal Code:

Phone # at site of care:

Does patient live alone? ☐ Yes ☐ No

Main caregiver name:

Relationship:

Caregiver Phone#:

Language spoken:

If not English, is an interpreter required & available? ☐ Yes ☐ No

Current location if not home:

If in hospital, hospital physician name and approx. date of discharge:

Power of Attorney

POA for Personal Care:

POA Contact information:

Caregiver/Physician Details

Family Physician:

Does family physician wish to share care of patient at home?

** Please note the family physician must be contacted and agree to CPMA referral*

Referring staff physician:

Print name _____ Signature of referring physician _____ OHIP Billing Number _____

NOTE: *If unable to electronically or physically sign this form, check here to acknowledge that the referral is being sent on authority of the person named above:* ☐

MANDATORY: Private Line/Cell Phone/Pager: _____ **Direct Fax number:** _____

Section 2: Palliative Issues

Life-limiting diagnosis:

Date of original diagnosis/pathology report:

Reason for referral at this time:

Current disease status:

☐ Stable ☐ Progressing ☐ Deteriorating rapidly ☐ Deteriorating slowly ☐ Other: _____

Future treatments planned:

Estimated prognosis:

Functional Status:

Current Palliative Performance Scale (PPS): *For PPS, see www.cpmaottawa.ca/pps*

Is functional status: Stable ☐ Declining: Daily ☐ Weekly ☐ Monthly ☐

Goals and Plan of Care:

What are the goals of care at this time?

Would the patient want to return to hospital to investigate and/or treat exacerbations or complications of their underlying condition?

DNR status confirmed: Yes ☐ No ☐

Any issues which would affect urgency of CPMA involvement:

Section 3: Other Medical Issues

Past Medical History (Please also attach a current list of medications and allergies):

Are you aware of any infection control issues?

Other relevant information (including mobility/access/mental capacity issues):

Section 4: Place of Care Issues

Are you aware of any safety, substance abuse, psychiatric or caregiver issues that could affect the ability to provide care in the home?