Huron Shores Hospice
24 King Street N
Tiverton, Ontario, N0G 2T0

REFERRAL FORM

Please fax to 519-368-8811

Date:_____

Referral Guidelines

1. To refer a patient, please complete this form and fax to 519-368-8811.
2. The admissions team will contact the patient or SDM within 72 hours to arrange a time for assessment.
3. Admissions to the residential hospice will be based on strict criteria, ensuring highest needs patients have priority.
4. The admissions team will provide feedback to the referring physician within one week of referral.

Patient Information

Last Name: _____ First Name: _____

Address: _____ Physician info: _____

_____ _____

Phone #: _____ Health Card #: _____

Primary Palliative Diagnosis: _____ Other relevant diagnosis/ symptoms: _____

Patient is currently:
- ❑ at home with no services
- ❑ at home with services
- ❑ in facility
- ❑ in hospital
- ❑ connected with LHIN Palliative Care Team
- ❑ on a waiting list for another residential hospice

❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Palliative Performance Scale (PPSv2)

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/house work 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	-	-	-	-

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Date:_____

Primary Contact Information

Last Name: _____ First Name: _____

Relationship: _____ Lives with patient: ❑ yes ❑ no

Phone #: (H) _____ POA Personal Care: ❑ yes ❑ no

(C) _____ SDM: ❑ yes ❑ no

Referral Information

Reason for Referral: ❑ Residential Hospice Bed Request ❑ Both

❑ Palliative Care Consultation (Pain & Symptom Management)

Relevant Attachments: ❑ Most recent CTX (chest xray) ❑ MAR/Home Medication List

❑ Most recent/relevant Patient History/Consultation reports

Referring Physician: _____

Telephone: _____

Signature: _____

Additional Notes

For Office Use Only

Date Received: _____ Assessment Date: _____

Referrals Made: _____ Acknowledgement Sent: _____

_____ Admission Date: _____