BRAMEAST FAMILY HEALTH ORGANIZATION
2130 NORTH PARK DRIVE, UNIT 38
BRAMPTON, ON, L6S 0C9
Tel (905) 792-2211
Fax (905) 792-2901

Brameast Community Palliative Care Referral Form

To avoid any delay in our response to your request, please complete all sections of the form below and enclose copies of any imaging reports, recent lab results and pertinent patient care notes/consults.

☐ **One Time Consult**	☐ **Urgent**
☐ **Ongoing Palliative Care**	☐ **Elective**

Patient Information:

Last Name: _____ **First Name**: _____

Date of Birth (Day, Month, Year): _____ **Gender**: _____

Health Card Number (with version code): _____ **Primary Language**: _____

Address: _____

Home Phone Number: _____ **Cell Phone Number**: _____

Primary Contacts*:*

Name	*Relationship*	*Phone Number*

Current location: ☐ Home ☐ Hospital – Anticipated Date of Discharge: _____

Palliative Care Diagnosis: _____ **Date of Diagnosis**: _____

Individual Aware of Diagnosis and Prognosis: ☐ Yes ☐ No
Anticipated Prognosis (if known): ☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ uncertain
Palliative Performance Scale (PPS): _____

Oncologist/Specialist: _____ **Location of Treatment**: _____

DNR: ☐ Yes ☐ No **EDITH* Form in Place**: ☐ Yes ☐ No **CCAC Services Started**: ☐ Yes ☐ No

Patient/Family Concerns Team should be aware of (i.e. substance abuse, symptom management concerns):

Referral Information:

Name of Family Physician: _____
Phone Number: _____ *Fax Number*: _____
Family Physician aware of referral: ☐ Yes ☐ No

Referring Physician/NP (please print): _____ **Billing number**: _____
Referring Physician/NP Signature: _____ **Date of Referral**: _____

****EDITH = expected death in the home***