St. Michael's
Inspired Care.
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70019

Patient ID

Palliative Care Service
Referral Form

Date of Referral: _____ Time: _____ Location: _____ Room: _____

Referring Service/ Unit: _____

Referring MD: _____ MD Signature/Title _____

Primary Diagnosis: _____

What is the estimated life expectancy? ☐ <1 month ☐ 1-3 months ☐ > 3 months.

Is patient DNR? ☐ Yes ☐ No Is pt/family aware of consult? ☐ Yes ☐ No

Is there further active treatment planned for Primary diagnosis?

☐ No ☐ Yes (please explain)

_____

_____

_____

Reason(s) for Referral:

1. Palliative Care Consultation regarding any of the following issues (please check all appropriate boxes):

   Symptom management: ☐ Pain ☐ Fatigue ☐ Nausea/ Vomiting ☐ Shortness of Breath ☐ Depression

   ☐ Anxiety ☐ Drowsiness ☐ Appetite ☐ Well being

   ☐ Other Problem _____

   ☐ Distress with diagnosis or prognosis

   ☐ Disharmony among caregivers (Family/ Professional Caregivers)

   ☐ Patient/Family Education Re: Palliative Care Options

2. ☐ Possible admission to Palliative Care Unit

Comments:

_____

_____

_____

Palliative Care Unit - Ext. 5226 Please FAX consultation request to: 416- 864-5297