Health PEI
One Island Health System

# Provincial Integrated Palliative Care Program
# Client Referral

| **Please FAX this form to the appropriate number below:** | | | |
|---|---|---|---|
| ☐ O'Leary | 902-859-8701 | ☐ Montague | 902-838-0774 |
| ☐ Summerside | 902-888-8439 | ☐ Souris | 902-687-7048 |
| ☐ Charlottetown | 902-368-4858 | | |

If you have questions about this form, please contact your local Home Care Office.

- **All sections must be completed, or the referral may be returned to sender.**
- **Eligibility for the Provincial Integrated Palliative Care Program will be determined by meeting the criteria on the reverse.**
- **By completing this referral, health care providers must be willing to collaborate with the Palliative Care Coordinator.**

**Client Information**

| Client Name | DOB | PHN |
|---|---|---|
| Address (including Civic Number and Postal Code) | | |
| Telephone: Cell: Text Y☐ N☐ Email: | | |
| Contact Person | Address (if different from client) | Relationship to Client: |
| Telephone: Cell: Text Y☐ N☐ Email: | | |
| Client's Living Arrangements ☐ Alone ☐ Spouse ☐ Family ☐ Other _____ | | |
| Is the contact person aware of this referral and client's palliative condition? Y☐ N☐ | | |

**Referral Source**

| Name of person/service making Referral | Date of Referral |
|---|---|
| Telephone:<br>Cell: Text: Y☐ N☐ | Email |
| Primary Care Provider (if different from above) | Telephone:<br>Cell: Text: Y☐ N☐<br>Email: |
| Alternate primary care provider when you are not available (include contact information): | |

**Goals of Care**

| Has Goals of Care been discussed? Y☐ N☐<br><br>Has Goals of Care form been completed? Y☐ N☐<br><br>What is the Goals of Care Status R ☐ M ☐ C ☐<br>(Please attach a copy) | Does the client have a health care directive? Y☐ N☐<br>(Please attach a copy) |
|---|---|

**Medical Information**

| Diagnosis | Reason for Referral |
|---|---|
| **Medical History required:** Attach completed Edmonton Symptom Assessment Scale (**ESAS-r**), Patient Reported Functional Status (**PRFS**), Recent bloodwork including **Albumin,** Current History, Physical, Consults, Clinical Notes. | |
| **If the request is urgent, provide rationale:** | |

**If you require a palliative care physician consult, please page/call or send a referral note provincial palliative care physician.**

**Provincial Integrated Palliative Care Program**

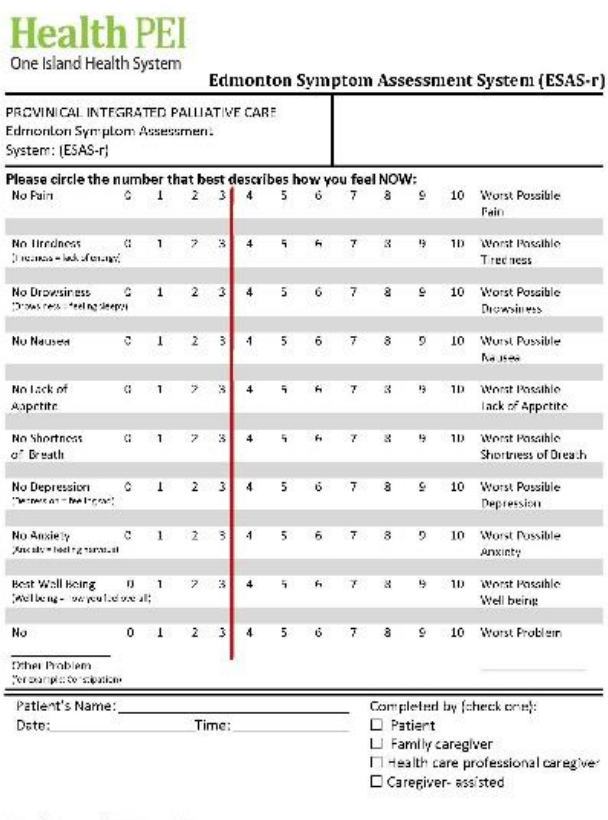
**Eligibility Criteria**

**Specialized palliative care at home** *(Please indicate all that apply)*

1. Diagnosis of progressive life-limiting illness
   - ☐ Disease specific indicators of significant decline {complex illnesses such as ALS}
   - ☐ And / Or PPS of 50 or lower
2. Client aware of and accepting of referral {for pediatric or cognitively impaired clients, parents or guardians aware and accepting}.
3. Client requires coordinated care for complicated palliative care needs as evidenced by 1 or more of:
   - ☐Palliative signs and symptoms that need management and cannot solely be managed by primary care provider
   - ☐Repeated unplanned crisis/admissions to facility based care
   - ☐Progressive weight loss (>10%) in past 6 months
   - ☐Serum albumin<28g/l
   - ☐Caregiver{s} demonstrating significant distress

Should a client not meet eligibility criteria for the Provincial Integrated Palliative Care Program, they may still meet eligibility criteria for a palliative approach to care through another Home Care Service. The Home Care Intake process will help determine the most appropriate service for each client.

Personal information on this form is collected by Health PEI under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act* and the *Health Information Act.* We will use this information for the purposes of processing your referral and providing care. For more information on the collection, use or disclosure of your information, visit www.healthpei.ca/yourprivacy or speak with your health care provider.



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**Edmonton Symptom Assessment System (ESAS-r)**

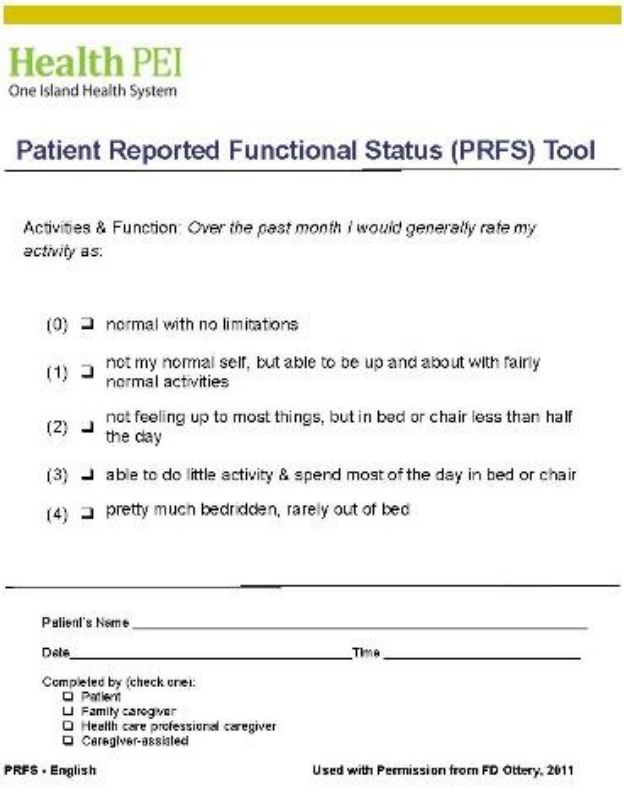
PROVINCIAL INTEGRATED PALLIATIVE CARE
Edmonton Symptom Assessment System: (ESAS-r)

**Please circle the number that best describes how you feel NOW:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Pain |
| No Tiredness (Tiredness = lack of energy) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Tiredness |
| No Drowsiness (Drowsy = feeling sleepy) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Drowsiness |
| No Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Nausea |
| No Lack of Appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Lack of Appetite |
| No Shortness of Breath | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Shortness of Breath |
| No Depression (Depressed = feeling sad) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Depression |
| No Anxiety (Anxious = feeling nervous) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Anxiety |
| Best Well Being (Well being = how you feel overall) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Well being |
| No _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Problem |
| Other Problem (For example: constipation) | | | | | | | | | | | | |

Patient's Name: _____
Date: _____ Time: _____

Completed by (check one):
☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver- assisted



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**Patient Reported Functional Status (PRFS) Tool**

Activities & Function: *Over the past month I would generally rate my activity as:*

(0) ❑ normal with no limitations
(1) ❑ not my normal self, but able to be up and about with fairly normal activities
(2) ❑ not feeling up to most things, but in bed or chair less than half the day
(3) ❑ able to do little activity & spend most of the day in bed or chair
(4) ❑ pretty much bedridden, rarely out of bed

Patient's Name _____
Date _____ Time _____

Completed by (check one):
☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver-assisted

PRFS - English

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