Health PEI
One Island Health System

Provincial Integrated Palliative Care Program
Client Referral

- **All sections must be completed, or the referral will be returned to sender for completion.**
- **Eligibility for the Provincial Integrated Palliative Care Program will be determined by meeting the criteria noted on page 2.**
- **The Primary Care Provider/NP must be aware and willing to collaborate with the Home Care Palliative Care Coordinator**.

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.

<table>
<tr><td rowspan="3">Client/Contact</td><td colspan="2">Client Name: DOB: PHN:
Address (including Civic Number and Postal Code)

Client's Living Arrangements: ☐ Alone ☐ Spouse ☐ Family ☐ Other
Telephone: Cell:
Email:</td></tr>
<tr><td colspan="2">Contact Person Name: Address (if different from client):
Relationship to Client:
Telephone:
Email:</td></tr>
<tr><td colspan="2">Is the contact person aware of this referral and client's palliative condition? Y☐ N☐</td></tr>
<tr><td rowspan="4">Referral Source</td><td>Name of person/service making Referral:</td><td>Date of Referral:</td></tr>
<tr><td>Telephone:
Text: Y☐ N☐</td><td>Email:</td></tr>
<tr><td>Primary Care Provider (if different from above)</td><td>Telephone:
Cell: Text: Y☐ N☐
Email:</td></tr>
<tr><td colspan="2">Alternate primary care provider when you are not available (include contact information):</td></tr>
<tr><td>Goals of Care</td><td>Goals of Care have been discussed (required)
Results of that discussion:</td><td>Does the client have a health care directive? Y☐ N☐

Has Goals of Care form been completed? Y☐ N☐

What is the Goals of Care Status? R ☐ M ☐ C ☐
(Please attach a copy for all the above)</td></tr>
</table>

Medical Information		
	Diagnosis	What is the reason for Referral?
	Medical History Required (Page 3 & 4 MUST BE COMPLETED) • Completed Edmonton Symptom Assessment Scale (**ESAS-r**) Page 3 • Completed Patient Reported Functional Status (**PRFS**) Page 4 • Recent bloodwork including **Albumin** • Current History &Physical • Consults • Clinical Notes • Completed Eligibility Criteria Section	
	If the request is urgent, provide rationale:	**Any other pertinent information to be aware of (risks/social/concerns etc.):**

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.

Health PEI Edmonton Symptom Assessment System (ESAS-r)

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 *(lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(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 *(feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No *'Other Problem'* _____ *(E.g., constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

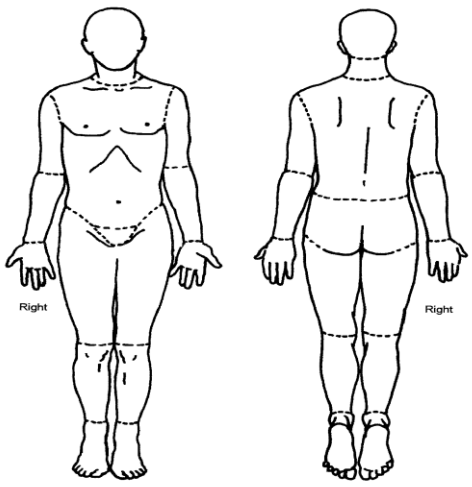
Patient's Name: _____

Date: _____ Time: _____

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

Please mark on these pictures where it is that you hurt

Please mark on these pictures where it is that you hurt:



Cancer Care Ontario
Action Cancer Ontario

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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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