Health PEI   Santé Î.-P.-É.

PROVINCIAL PALLIATIVE CARE CENTRE

93 MURCHISON LANE, CHARLOTTETOWN, PE C1A 0G3
TEL: (902) 368-4781   FAX: (902) 620-3473

APPLICATION FOR ADMISSION

FAX COMPLETED APPLICATION TO: (902) 620-3473

Section A: General Information

Name of Patient: ____

DOB (M/D/Y): ______________________ Sex: ______ PHN: ________________ Tel: ___________________

Address: ____ Postal Code: ______________

SDM/Proxy: ____ Tel: ___________________

Family Physician: ______________________________ Source of Referral: ___________________________

- Has Code Status/Goals of Care been discussed with the patient?

  ☐ Yes ☐ No

- What is the patient's code status/goals of care?

  ☐ R ☐ M ☐ C

Section B: Admission Criteria

Palliative diagnosis has been established and requires:

1. Pain & Symptom Management
2. Crisis Management – *including caregiver burnout or other forms of distress*
3. Complex Respite – *e.g. social, psychosocial, crisis, physically complex diagnosis (ALS)*

Guiding Principles

1. Any individual who has been informed by the admitting team of the Provincial Palliative Care Centre (PPCC) that they have been offered the next bed will not be displaced from this position. Once the promise of a bed has been made, unless it is the patient's choice to decline, the patient will be provided the next bed.
2. The Application for Admission to PPCC must be accepted by the admitting team at the centre. Applications deemed not appropriate for any reason will be returned to the referral source.
3. Patients must be willing to accept the bed at the time of signing the application. The patient must be willing to come to the bed once it has been offered. There will be some cases where an individual has an event planned and will delay admission by 24-48 hours.
4. Admission to PPCC for terminal care will generally have a length of stay of less than three (3) months. *It is recognized that prognosis is not an exact science and in some cases a stay will exceed 3 months, but as a rule this should not occur.*
5. The assessment to determine the patient's priority for admission to PPCC must be done by a member of the Palliative Care Team. If the patient is at home, the assessment may be completed by the Palliative Care Coordinator.

- **ESAS SCORES**

PAIN	
TIREDNESS	
DROWSINESS	
NAUSEA	
LACK OF APPETITE	
SHORTNESS OF BREATH	
DEPRESSION	
ANXIETY	
WELL-BEING	

COMPLETED BY *(check one)*:

☐ Patient
☐ Family Caregiver
☐ Health Care Professional Caregiver
☐ Caregiver Assisted

DATE: ________________________________

SIGNATURE: ___________________________

- **ALBUMIN LEVEL:** ____________________ **DATE:** ______________________
- **PPS SCORE:** ________________________ **DATE:** ______________________

NAME (PRINTED): _______________________ **SIGNATURE:** ______________________________ **DATE:** _______________

Section C: To be reviewed and signed by applicant or responsible person when applying for Palliative Care

Palliative care aims at enhancing the quality of life of individuals and families affected by a life limiting illness. It aims at helping people live life as fully as possible until their natural death.

The provision of Medical Assistance in Dying (MAiD) is a practice separate and distinct from palliative care. Patients who are admitted to the Provincial Palliative Care Centre (PPCC) are admitted for the purpose of receiving palliative care. However, we recognize that patients have choices and these choices may change over time. We respect patient choice and will facilitate conversation and referral to the MAiD service if a patient wishes.

Statement of Understanding of Palliative Care

I understand that patients receiving palliative care will be reviewed regularly and could be transferred/ discharged should their condition warrant.

Client Consent for Sharing Health Information

The Provincial Integrated Palliative Care Program is a network of services delivered by a team of health care providers which may include your family physician, specialists, nurses in the community or the hospital, home support workers, volunteers, pastoral care providers, pharmacists, and others. Services involved with your care plan will depend on your needs. In order to ensure quality care, it is necessary to share your information among team members involved. ***The sharing of your information will be undertaken with the greatest respect for your privacy.***

I, ______________________________________, give permission for team members involved in my care at home, in hospital, a palliative care unit, or with the Provincial Integrated Palliative Care Program:

- To access my medical records and/or personal information as required from my hospital records, my physician and all other agencies or departments as may be necessary for the purpose of assessment of my needs, provision of services to me, and Provincial Integrated Palliative Care Program evaluation.
- To share medical and/or personal information about myself to the extent necessary within the Provincial Integrated Palliative Care Program with appropriate care providers.

I understand that this consent is valid unless revoked by me verbally or in writing. I also understand that I may revoke this consent verbally or in writing at any time.

____ ____

(SIGNATURE OF APPLICANT OR SUBSTITUTE DECISION-MAKER) **(DATE)**