

Central Intake: Milton Community Palliative Care Physicians Referral



INCLUSION CRITERIA: PPS ≤30% PROGNOSIS <8 weeks LIVES IN MILTON AREA (see over)

Referring provider (or Family Physician) agrees to remain MRP until patient is seen & accepted by CPCP ____initial
 Referring provider agrees to resume MRP care if patient improves & no longer meets inclusion criteria ____initial
 If CPCP accepts patient, all Physicians agree to stop billing G512 code ____initial

****PATIENTS WILL BE CONTACTED WITHIN 1 WEEK OF REFERRAL ACCEPTANCE - THIS IS NOT AN EMERGENT/URGENT CONSULT SERVICE****

PATIENT DEMOGRAPHICS		
Patient Name:		DOB:
HCN:	VC:	Gender:
Address:		
Phone Numbers:		
Language:		Translation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital		Anticipated Discharge Date:
Living Arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family		
Is Home and Community Care Support Services (HCCSS) Involved? <input type="checkbox"/> YES <input type="checkbox"/> NO (if no, please complete HCCSS Palliative Referral)		
Current Homecare Supports: <input type="checkbox"/> PSW <input type="checkbox"/> Nursing <input type="checkbox"/> NP <input type="checkbox"/> Other:		

ALTERNATE CONTACT NAME	RELATIONSHIP	PHONE NUMBER

Who to contact with appointment:

MEDICAL INFORMATION:	
Palliative Care Diagnosis:	Date of Diagnosis:
Other Medical History:	
Allergies:	<input type="checkbox"/> MRSA/VRE/ESBL
Current Symptoms/Concerns:	
Palliative Performance Scale (PPS):	Details:
DNR: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Discussed with family (REQUIRED) Prognosis: <input type="checkbox"/> days to weeks (REQUIRED)	
Patient aware of Diagnosis, Prognosis and Referral to Palliative Care (REQUIRED) <input type="checkbox"/> Yes	

FAMILY MD INFORMATION		
Name:	Phone:	Fax:
Family MD has been contacted and aware of the referral (REQUIRED) <input type="checkbox"/> Yes		

REFERRAL SOURCE	
Name:	MD/NP Billing Number (REQUIRED):
Phone (<i>Backline/Cell Preferred</i>):	Fax:
Signature:	Date of Referral:

ADDITIONAL INFORMATION ATTACHED (REQUIRED):

- Medication and Dosages Labs and Imaging Consultations/ Recent Clinical Notes

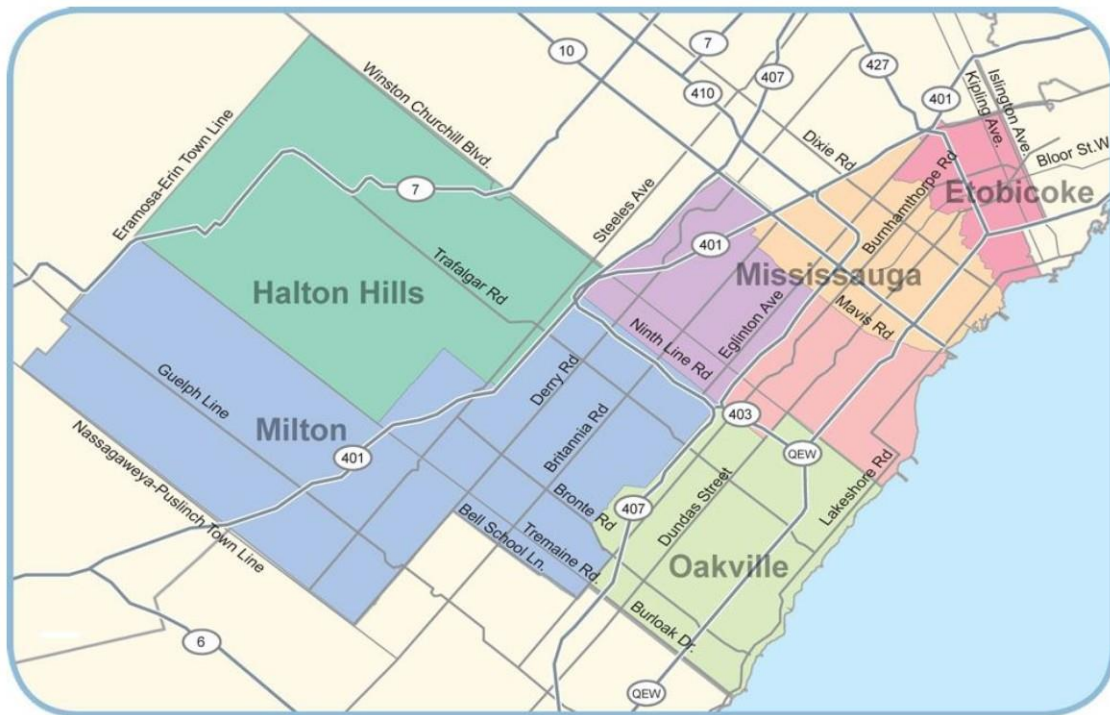
Central Intake Phone No: 905-855-9090

PLEASE FAX REFERRAL FORM AND ALL ACCOMPANYING DOCUMENTATION TO FAX No.: 905-338-4434

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Questions? Email us at Milton CPCP@haltonhealthcare.com



PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Consciousness Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/housework Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	----	---	---	---

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