Interlake-Eastern
Regional Health Authority

Palliative Care Program
Registration Referral Form

Complete all sections and forward to FAX: 204-785-4895 OFFICE: 204-785-7537 For Referral Inquiries ONLY

CLIENT IDENTIFICATION

Full Legal Name:	Male: ☐ Female: ☐	
Address:		Client Telephone:
Date Of Birth: MHSC: PHIN:		CR#:
• **Location of Patient at time of Referral:** ☐ **Home** ☐ **Hospital** ☐**PCH**		
Next of Kin Name: Address	Relationship: Telephone Number:	
Referring Site/Program/Contact #:		
Name of Practitioner (MD or NP) Making Referral	Telephone:	
Is Client's Primary Care Practitioner aware of referral? ☐Yes ☐No		

CLINICAL INFORMATION

Primary Diagnosis/ Summary of Progression of Disease:

Date of Diagnosis:

Urgency of Referral ☐IMMEDIATE ATTENTION ☐ ATTENTION WITHIN 1 WEEK

Estimated Prognosis:
☐Less than one month ☐Less than 3 months ☐3 to 6 months ☐Over 6 months

Treatment History: (date of last Tx) Is any further treatment planned? (Specify)

Current Issues: (Symptom Management/Psychosocial/Spiritual/Functional Decline)

Is client currently known to Home Care? ☐Yes ☐No

What services are requested?
☐MD Consult ☐Referral To Program ☐Psychosocial Support ☐Volunteer Services

Patient and family are aware of referral to Palliative Care Program: ☐Yes ☐No

Does the patient have an Advance Health Care Directive: ☐ Yes ☐No If No, has it been discussed: ☐Yes ☐No

Has the patient been informed of: **Diagnosis** ☐Yes ☐No **Prognosis** ☐Yes ☐No

Has the family been informed of: **Diagnosis** ☐ Yes ☐No **Prognosis** ☐Yes ☐No

Signature of Practitioner (MD or NP) making referral: Date:

FOR OFFICE USE ONLY: ☐Accepted ☐Pending ☐Rejected Date:
Explanation (Pending/Rejected):