



Admission Referral for Community Hospice

PATIENT INFORMATION		PROVIDER INFORMATION	
First name	Referring practitioner		
Last name	MSP #	<input type="checkbox"/> Locum	
Date of birth (dd-Mmm-yyyy)	STAMP		
PHN			
Primary contact number			
Address	Will the referring provider be MRP at Hospice? (N/A Victoria Hospice) <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Name of admitting provider: _____		
MRN (optional)	Admitting MD/NP aware: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician aware: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Person identifies as Indigenous <input type="checkbox"/> Yes <input type="checkbox"/> No			
REFERRAL INFORMATION			
Present Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other		Primary Contact Person	
Patient Diagnosis		Name:	
		Relationship:	
		Phone:	
CLINICAL PATIENT INFORMATION			
NOTE: Attach medical information to support referral (non-cancer or non-metastatic cancer, specific information to support prognosis)			
Request Reason/s <input type="checkbox"/> Unable to manage care at home <input type="checkbox"/> Caregiver Break / Respite (patient hope to return home) <input type="checkbox"/> Improve Symptom management			
<input type="checkbox"/> Estimated prognosis <12 weeks <input type="checkbox"/> Goals of care = Hospice care <input type="checkbox"/> BC no CPR or MOST M1 or M2, if admitted, requires MOST <input type="checkbox"/> Patient Agree to Referral		Palliative Performance Score (PPS) % _____ BC Palliative Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No Safety Considerations <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Pt/Family aware of Per Diem <input type="checkbox"/> Yes <input type="checkbox"/> No Family Aware of Referral <input type="checkbox"/> Yes <input type="checkbox"/> No Active ICD (Implant Cardio Defib) <input type="checkbox"/> Yes <input type="checkbox"/> No MAiD Request <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No		Infectious Considerations <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: TB Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No neg screen or Mantoux or chest x-ray in last year (N/A Vic Hospice)	
Caregiver / Family Considerations:			
ROUTING			
Fax Referral AND Medical Information to 'Hospice Admission Panel' to the requested Hospice location			
Date of Referral (dd-Mmm-yyyy):			
<input type="checkbox"/> Hospice at Trillium Lodge (Parksville) 250-947-8227 <input type="checkbox"/> Hospice at Yucalta Lodge (Campbell River) 250-850-2917 <input type="checkbox"/> Hospice at Chemainus Health Centre 250-737-2656 <input type="checkbox"/> Cowichan Hospice House (Duncan) 250-737-2656		<input type="checkbox"/> Aitken Community Hospice (Comox) 1-236-337-7106 <input type="checkbox"/> Hospice at Ayre Manor (Sooke) 250-642-1754 <input type="checkbox"/> Victoria Hospice Unit 250-370-8625	

