Island Health

Referral for Community Palliative Consult Team / Symptom Clinic

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (ddMmmyyyy)
PHN	MRN *(Optional):*	Primary Phone #:
Address:	Alternate Name & Phone #:	

PROVIDER INFORMATION

Referring Provider:	MSP #:	☐ Locum
Clinic Name:	Phone#:	Fax#:
Street Address:		
Primary Care Provider: ☐ Same as ordering provider	Copy to (full name):	

REASON FOR REFERRAL

Please describe reason for referral:

☐ Attach medical history (exclude PowerChart and BCCA notes)
☐ Attach medication list and allergies

CLINICAL PATIENT INFORMATION

Palliative Diagnosis:	**Palliative Performance Scale (PPS) %:**

☐ Primary Care Provider must agree to consult ☐ Patient / Family must agree to consult Palliative Benefits Approved ☐ Yes ☐ No

MOST: ☐ Yes ☐ No **Designation:** ☐ M1 ☐ M2 ☐ M3 ☐ C0 ☐ C1 ☐ C2

Physician Consult: ☐ Home or Symptom Clinic Visit ☐ Facility (LTC) Visit

ROUTING- Select appropriate community

☐ Campbell River	☐ Comox Valley	☐ Cowichan / Ladysmith
☐ South Island	☐ Mt Waddington *(Telehealth)*	☐ Nanaimo
☐ Parksville / Qualicum *(Oceanside)*	☐ Port Alberni / West Coast	

FAX this referral and ALL related documents to: 250-755-6237

NOTE: CHS home nursing is a separate referral and strongly recommended

If your client also requires CHS home nursing or other services, please complete a CHS referral form and send via Community Access