



**NORTH  
YORK  
GENERAL**

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**PAIN AND SYMPTOM MANAGEMENT CLINIC  
REFERRAL FORM**

Form SF0022

Rev. 11/2017

The NYGH Pain and Symptom Management Clinic consists of a team of palliative care health care providers who work with a referring NYGH physician to manage complex pain and symptom issues related to a **cancer diagnosis**. This is an outpatient consultation clinic.

Please **fax** completed referral forms to **416-756-6833**. Please **call 416-756-6529** if you have questions or concerns.

<b>Patient Name:</b> _____		<b>DOB:</b> _____	<b>Gender:</b> _____	<b>Does the patient speak English?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Health Card Number and Version Code</b> _____		If no, which language: _____
<b>Home Phone:</b> _____	<b>Contact for appointment:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Alternate		<b>Is the patient capable of decision making/providing consent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Work/Cell Phone:</b> _____	<i>If alternate, indicate:</i>		If no, please explain: _____	
<b>Referral Type:</b> <input type="checkbox"/> New referral to Pain & Symptom Management Clinic <input type="checkbox"/> Follow-up from hospital	Relationship: _____		_____	
		Phone Number: _____		
<b>Primary Cancer Diagnosis / Other Medical Diagnoses:</b>			<b>Current treatment plan:</b>	
Is there metastatic spread? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> chemo <input type="checkbox"/> hormone <input type="checkbox"/> radiation <input type="checkbox"/> clinical trial	
If yes, please give details: _____			<input type="checkbox"/> Other: _____	
_____			_____	
_____			_____	
<b>Reason for referral:</b> <input type="checkbox"/> Pain and Symptom Management <input type="checkbox"/> Goals of Care <input type="checkbox"/> End-of-life Care <input type="checkbox"/> Other/Specific Concerns: _____			<b>Intent of treatment:</b> <input type="checkbox"/> Curative <input type="checkbox"/> Non-curative <input type="checkbox"/> Unknown	
_____			<b>Urgency to be seen:</b> <input type="checkbox"/> 1-2 days* <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 2-4 weeks	
_____			<b>*If URGENT – must call the on-call palliative care MD directly and submit this form* (Please see reverse for instructions)</b>	
<b>Current symptom issues and treatment:</b>			<b>Prognosis:</b>	
_____			<input type="checkbox"/> Days-Weeks	
_____			<input type="checkbox"/> Weeks-Months	
_____			<input type="checkbox"/> Month-Years	
_____			<input type="checkbox"/> Unknown	
			<b>Palliative Performance Scale (PPS) (Please see reverse for PPS scale):</b>	
			PPS: _____%	

Referring MD

Signature

Phone

Date

**Information for referring physicians**

1. All URGENT referrals must be directly communicated to the **on-call palliative MD** through locating at: **416-756-6002**.
2. Only patients with a **primary diagnosis of cancer** will be seen in the Pain and Symptom Management Clinic.
3. Referrals from outside the hospital must be accompanied by appropriate clinical information including consultations and clinical notes, laboratory and diagnostic information, and medications with dosages.

***Palliative Performance Scale (PPSv2)***  
***version 2***

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious 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 <i>with</i> 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/house work 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 Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death				

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Appt Date: _____	Time: _____	MD: _____
Appt: details given to: <input type="checkbox"/> Patient <input type="checkbox"/> Other: _____	Date notified: _____	
Date received: _____	Staff signature: _____	