NORTH YORK GENERAL

Making a World of Difference

Palliative Care Clinic REFERRAL FORM

FORM SF0330 **Page 1 of 2** **Rev. 08/2021**

The NYGH Palliative Care Clinic (formerly 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.

Patient Name:	**DOB:**	**Gender:**	**Does the patient speak English?** ☐ Yes ☐ No
	Health Card Number and Version Code		If no, which language:_____
Home Phone: _____ **Work/Cell Phone:** _____	**Contact for appointment:** ☐ Patient ☐ Alternate *If alternate, indicate:* Relationship:_____ Phone Number:_____		**Is the patient capable of decision making/providing consent?** ☐ Yes ☐ No If no, please explain:_____
Referral Type: ☐ New referral to Palliative Care Clinic ☐ Follow-up from hospital			
Primary Cancer Diagnosis / Other Medical Diagnoses: **Is there metastatic spread?** ☐ Yes ☐ No **If yes, please give details:** _____			**Current treatment plan:** ☐ chemo ☐ hormone ☐ radiation ☐ clinical trial ☐ Other:_____ ☐ Patient does not want treatment ☐ Patient is not eligible for treatment – please explain: _____
Reason for referral: ☐ Pain and Symptom Management ☐ Goals of Care ☐ End-of-life Care ☐ Other/Specific Concerns: _____			**Intent of treatment:** ☐ Curative ☐ Non-curative ☐ Unknown **Urgency to be seen:** ☐ 1-2 days* ☐ 1-2 weeks ☐ 2-4 weeks ***If URGENT – must call the on-call palliative care MD directly and submit this form* (Please see reverse for instructions)***
Current symptom issues and treatment:		**Prognosis:** ☐ Days-Weeks ☐ Weeks-Months ☐ Month-Years ☐ Unknown	**Palliative Performance Scale (PPS) (Please see reverse for PPS scale):** **PPS:_____%**

Referring MD **Signature**

Phone **Date**

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 Palliative Care 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 *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/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				

For Office Use Only

Appt Date:_____ Time:_____ MD: _____

Appt: details given to: ☐ Patient ☐ Other:_____ Date notified: _____

Date received: _____ Staff signature: _____