Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

HOSPICE/HOSPICE RESPITE REF

Name:		**PARIS ID:**
DOB:	**Age:**	**PHN:**
Gender:		**Phone:**
Home Address:		

Assessment Start Date: **Assessment End Date:** **Carried Out By:**

Referral Source and Request Information

☐ New Referral ☐ Re-Referral

Referral Source Details

Community Team: ☐ North Shore

Hospital: ☐ Fraser Health

Unit: ☐ Other, Specify:

Has the Hospital Palliative Consult Service been involved? ☐ Yes ☐ No

GP Name:

Telephone:

Fax:

Referral Originated By:

Title:

Telephone: Date:

Fax: Pager:

Comments:

Referral Request Details

☐ Hospice Preference #1: ☐ Only Acceptable Preference

Hospice Preference #2:

☐ Respite Care (1wk) From: To:

Urgency of Referral

☐ Client otherwise requires ER admission within the next 24 hours

☐ Client is ready for hospice now (within 48 hours notice)

☐ Client is presently receiving Shiftcare Nursing

☐ Future care estimate; probable admission less than 1 month

Healthcare contact for hospice admission when bed available, if different from "Referral Originated By"

Name:

Telephone: Fax:

Comments:

Client Information

Marital Status:

Religion:

HOSPICE/HOSPICE RESPITE REF

Name:	PARIS ID:

Associated People

Name	Phone	Relationship	Association

Unregistered Contacts

Contact Name	Primary Number	Alternate Number	Association	Comments

Health Care Decision Maker

Date Recorded	Client	Substitute Decision Maker	Contact	Association	Phone Number	Alternate Number	Comments

Client Instructions for Financial and Legal

Date Recorded	Type	Document Location	Recorded By

Person Responsible for Fees

This section must be completed in order for the Hospice or Hospice Respite Referral to be accepted

Client/Family agree to pay daily Standard User Fee (Rate Code A) ☐ Yes ☐ No

☐ Patient on Social Assisstance

If Waiver is requested, Application for Temporary Rate Reduction MUST be completed before referral accepted

Person (responsible for payment other than client):

Address:

Telephone:

Palliative Performance Scale (PPS)

Assessed By	Assessment Date	PPS %	Comments

HOSPICE/HOSPICE RESPITE REF

Name:	PARIS ID:

Prognosis

Recorded By	Record Date	Prognosis	End Date	Entered at time of Registry?

Allergies - Current

A / S	Date Entered	Allergen	Reaction	Comment

Additional Client Information

Present Functional Status:

☐ Independent ☐ 1 Person Assist ☐ 2 Person Assist ☐ Bedbound

Why Does Client Need Hospice/Hospice Respite Placement

☐ Client is presently receiving Shiftcare Nursing and client's condition has stabilized

☐ Client and / or family express a desire for the client not to die at home

☐ Client requires ongoing symptom management (but not acute symptom management requiring medical treatment in an acute care setting)

☐ Client requires care needs that cannot be met at home

☐ Client has insufficient / unsafe caregiver support at home

☐ Physical setting is unsafe for client

☐ Physical setting is unsafe for caregivers

☐ Psychological-social distress within immediate family

☐ Client/family wish respite placement

Other Considerations

☐ Alcohol misuse / present use

☐ Altered cognitive state

☐ Drug misuse / present use

☐ Wanders

☐ Mental Health issues

☐ Smoking

☐ Safety Risk (falls, judgment, aggression)

☐ Other, Specify:

Pain Assessment Summary

Comments - consider Palliates/Provokes, Quality, Radiation/Location, Severity, Timing (Onset, Daily Pattern, etc), Understanding of Pain/Impact/ Distress, Values and Beliefs regarding pain/pain management:

Additional Client Information Comments, Include Formalized Tests (ie: ECOG, ESAS from BCCA):

HOSPICE/HOSPICE RESPITE REF

Name:	PARIS ID:

Physician Coverage

Is GP continuing to provide 24 hour care? ☐ Yes ☐ No

GP will provide 24 hour care at:

☐ Cottage Hospice ☐ Marion Hospice ☐ May's Hospice ☐ Richmond Hospice

Client will require care by Hospice Physicians ☐ Yes ☐ No

GP: GP Telephone:

GP Address:

Additional GP Contact Information:

Languages and Communication

Main	Language	Fluency	Interpreter Required	Comments

Additional Communication Information

Client Comprehension ☐ Yes ☐ No ☐ Fluctuates ☐ Unknown

Can Client Express Needs? ☐ Yes ☐ No

How Does Client Express Needs? ☐ Verbal ☐ Writing ☐ Word Board ☐ Sign Language ☐ Communication Device ☐ Other, Specify:

Comments:

Equipment

To be ordered by Referral Source before admission

☐ Any supplies or equipment presently in use
☐ Enteral Feeds - can bring unused feeds from home
☐ Infusion Pumps - Kangaroo, IVAC, etc can be brought from home
☐ Other

Comments:

HOSPICE/HOSPICE RESPITE REF

Name: **PARIS ID:**

Care Provider Information

This section must be complete in order for the Hospice Referral to be Accepted

Date of discussion:

The client / family agree with the philosophy and comfort care only emphasis of hospice

☐ Yes ☐ No

Health Care Provider (name): , has shared and discussed:

☐ Diagnosis, prognosis and hospice philosophy, including Do Not Resuscitate with

☐ Client and/or

☐ Alternative decision-maker (name):

Comments:

Required Information

To be completed & faxed at time of referral

	Sent
Medical History and Physical (within last 30 days)	☐
Copy of the BC Palliative Benefits Program application	☐
Copy of relevant consultations	☐
Current list of medications or MAR, if external referral source	☐
Copy of BC Provincial No Cardiopulmonary Resuscitation form (if completed)	☐

Funding and Income Source(s)

Funding Type	Funding Detail	Funding ID	Level Of Funding	Valid From	Valid To

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Casenotes

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

---------- End of Report ----------