Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

PALLIATIVE VISITOR REFERRAL FORM

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

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

Background

Does the client smoke?	☐ Yes	☐ No
Client aware of diagnosis and prognosis?	☐ Yes	☐ No
Have you spoken to the client about a volunteer?	☐ Yes	☐ No

Prognosis

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

Client Instructions For Health Care

Date Recorded	Type	Document Location	Entered at time of Registry?	End Date
			☐	

Contacts

Contact Name	Primary Number	Alternate Number	Association	Comments

General Information

Expectation of Volunteer

PALLIATIVE VISITOR REFERRAL FORM

Name: **PARIS ID:**

Special Instructions

Needs

Need	Post to C/P	Processed	Comments

Casenote

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

-- End of Report --