Hospice North Hastings
CARING WHEN THERE IS NO CURING

Referral Form-Medical Eligibility Determination

Please Complete the form and fax to 613-332-8017. If no response in 12 hours, please call 612-332-8014 *Please note that a OHAH (Ontario health at home) referral also needs to be sent separately with each referral to HNH.

Services Requested ☐ ***All***				
☐ **Residential Hospice** ☐ **Home Visiting Program** ☐ **Grief and Bereavement Counselling**				
Patient Information				
Name:	***D.O.B:***	***Age:***	***Weight:***	***Height:***
Diagnosis:	***Prognosis:*** ☐ < 1month ☐< 3months ☐ < 6 months	***PPS:***	***MAID discussed? YES NO Plan?***	
Individual Aware of: ☐ ***Diagnosis*** ☐ ***Prognosis*** ☐ ***Does not wish to know***			***If family is not aware, patient has given consent to inform family of: Diagnosis*** ☐ ***Yes*** ☐ ***No Prognosis:*** ☐ ***Yes*** ☐ ***No***	
Family aware of: ☐ ***Diagnosis*** ☐ ***Prognosis*** ☐ ***Does not wish to know***				
Mobility/Hearing/Pain/Behaviors/etc.:			***Spiritual Care Requests:***	
OHAH Coordinator (if applicable):		***HCN:***		***DNR: YES NO***
Gender: ☐ ***Prefer not to disclose*** ☐ ***I prefer to identify as: _____***			***Sex:*** ☐ ***Male*** ☐ ***Female*** ☐ ***Intersex***	
Pronoun patient identifies with (e.g: he, she, they, ze):		***Present Location (i.e.: home, hospital, LTC, ED):***		
Address:		***Phone:***	***Email:***	
Allergies:	***Infectious Diseases:*** ☐ ***MRSA*** ☐ ***VRE*** ☐ ***C Diff.*** ☐ Hep C ☐ Covid 19 ☐ ***Other: _____***			
Special care considerations (please check all that apply): ☐ ***Central line*** ☐ ***Pain pump*** ☐ ***Wound: _____*** ☐ ***Tracheostomy*** ☐ ***Drain: _____*** ☐ ***Oxygen: how many L/min_____ Type of oxygen delivery system:_____*** ☐ ***Cognition/Dementia*** ☐ ***Pacemaker*** ☐ ***Internal defibrillator: Has it been deactivated*** ☐ ***Yes*** ☐ ***No***				
Care Issues (please check all that apply)				
☐ ***EOL care/Death Management*** ☐ ***Pain & Symptom management*** ☐ ***Social Work*** ☐ ***Psychological*** ☐ ***Loss & Grief***				
Referral Information				
Referred By:	***Relation to Patient:***		***Date of referral:***	
Consent from patient/POA? YES NO	***Is patient aware of referral? YES NO***		***Phone Number:***	
Reason for Referral: ☐ ***EOL care needs exceed capacity of care home*** ☐ ***Caregivers/and or informal supports inability to cope at home*** ☐ ***Individual does not wish to die at home*** ☐ ***Pain and symptom management*** ☐ ***Other:_____***				
Physician Information				
Family Physician/Primary Care Practitioner:		**Phone:**	**Fax:**	
Most Responsible Physician:		**Phone:**	**Fax:**	
Nurse Practitioner (if applicable):		**Phone:**	**Fax:**	
Person to Contact on Behalf of the Patient				
Name:	***Phone:***	***Secondary Phone:***		
Address:		***Relationship to Patient:***		
Alternate Contact Person				
Name:	***Phone:***	***Secondary Phone:***		
Address:		***Relationship to Patient:***		
POA Information (Please attach document if available)				
Medical POA? YES NO Unknown Name:		***Relationship:***		
POA for Property Decisions: YES NO Unknown Name:		***Relationship:***		
Does Patient have a Advanced Care Directive? YES NO (please encourage advance care planning between patient and POA)				
RELEVANT ATTACHMENTS (please provide the following documentation with this referral)				
☐ ***Most recent/relevant Patient History/ Consultation reports*** ☐ ***MAR/Home Medication List*** ☐ ***Most recent Physician, Nursing, Allied Health Progress Notes***				

27 Bridge Street East, PO Box 875 Bancroft, ON KOL 1CO
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{E) info@hospicenorthhastings.com

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