

Referral Form: Supportive and Palliative Care Clinic (SPCC)

Criteria for the SPCC includes pain, symptoms, and psychosocial issues related to a life-limiting illness.

Please note that we are **NOT** a chronic pain clinic and do not manage chronic pain issues.

Consultant/Clinic/Service: _____

Referring Physician/Nurse Practitioner: _____ Billing Number: _____

Patient Name: _____ Date of Birth: _____

Health Card Number & Version Code: _____

Telephone: _____ Alternative Family Contact #: _____ Relationship: _____

Address: _____

Language: _____ Language Interpreter Required: ☐ Yes ☐ No

Diagnosis & Notes: _____

☐ **One Time Consultation**

☐ **Follow Up**

Palliative Performance Scale: 10-100% (please see attached) PPS: _____ Date: _____

REASON FOR REFERRAL

- ☐ Symptom Management
☐ Decision Making
☐ Psychosocial / Family Support
☐ End of Life Care
☐ Other: _____

TRIAGE URGENCY: [to be completed by referring physician]

- ☐ **Emergent** (< 1 week) e.g., pain or symptom crisis
☐ **Urgent** (1-2 weeks) e.g., psychosocial crisis; family support; pain/symptom management; transitioning to home care
☐ **Non-Urgent** (2-4 weeks) e.g., discharge planning; decision making; information/education re: palliative care

Physician Signature: _____ Date: _____

Telephone: _____

For Office Use Only

Appt Date: _____ Appt Time: _____ Date Notified: _____

Appt given to: ☐ Patient ☐ Other: _____ By Whom: _____

Information for Referring Physician/Practitioner

- Referrals must be accompanied by current and pertinent clinical information including consultations, clinical notes, laboratory and diagnostic information.
- Referrals are reviewed and appointments scheduled based on the stated urgency (see below), the Palliative Performance Scale (see below) and the patient's residence within the catchment area of the Central West LHIN.
- The patient will be seen and assessed by the palliative care physician and members of the team. A care plan will be developed based on the patient's current needs. The assessment and recommendations will be reviewed with the patient and family and provided to the referring physician and primary care physician (if different from the referring physician).
- Follow up care may be designated to the referring physician, the primary care physician or practitioner or the Palliative Care Clinic. Follow up care may also be shared between the primary care physician or practitioner and the Palliative Care Clinic. The Palliative Care Clinic does not automatically assume primary care for all referred patients.

Urgency

Symptoms are best rated using a 10 point scale (0 none-10 worst) i.e. the Edmonton Symptom Assessment Scale.

Emergent (<1 week): Severe symptoms (7 – 10/10), severe psychosocial distress or dysfunction or prognosis < 1 month

Urgent (1-2 weeks): Moderate symptoms (4 – 6/10), moderate psychosocial difficulties or prognosis 1 – 3 months

Non-Urgent (2-4 weeks): No or mild symptoms or prognosis 3 – 12 month



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	-	-	-	-

Cancer Care Ontario

Action Cancer Ontario

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):

- ☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r

Revised: November 2010

Please mark on these pictures where it is that you hurt:

