Palliative Care Program

Application for Registration

Complete all sections of this form and forward to:
(Incomplete forms may delay processing.)

WRHA Palliative Care Program
A8024 - 409 Taché Avenue
Winnipeg, Manitoba, R2H 2A6
Phone: (204) 237-2400
Fax: (204) 237-9162

Addressograph	Date:
	Person Referring Patient:
	Source of Referring Agency:
	Telephone:

CLIENT IDENTIFICATION

Full Name:		Male: ☐ Female: ☐
Address:		Telephone:
Date of Birth (Day / Month / Year)	MHSC Family Number:	PHIN Number:
Next of Kin Name:		Relationship:
Address:		Telephone:
Primary Physician or Nurse Practitioner Name:	Fax Number:	Telephone:
Name of Health Care Provider:	Fax Number:	Telephone:
Name of Health Care Provider:	Fax Number:	Telephone:
Name of Psychosocial Clinician:	Fax Number:	Telephone:

CLINICAL INFORMATION

Primary Diagnosis / Known Metastases & Summary of Progression of Disease:

Date of Diagnosis:

Urgency of Referral: Immediate Attention: ☐ Attention Within 2 Weeks: ☐

Estimated Prognosis: Less than one week ☐ Less than one month ☐ 1 to 3 months ☐ 3 to 6 months ☐ Over 6 months ☐

Treatment History: ChemoTx (date of last Tx). Radiation Therapy (where & when). Further treatment planned? Specify. Recent Investigations (Please attach information).

Current Issues: (Symptom Management / Psychosocial / Spiritual / Functional Decline)

Past Medical History:

Past/Present Alcohol Use: Smoker:

Allergies or Medication Intolerances (Please Describe):

Current Medications: (Specify doses and frequency)

CURRENT FUNCTIONAL STATUS

	Independent	Partial Assist	Complete
Ambulation:	☐	☐	☐
Transfers:	☐	☐	☐
Continence:	☐	☐	☐
Bathing:	☐	☐	☐
Dressing:	☐	☐	☐
Ability to feed self:	☐	☐	☐

Comments:

COGNITION:	No issues identified ☐	Intermittently Confused ☐	Consistently Confused ☐
MOOD:	Anxious ☐	Depressed ☐	Agitated ☐
BEHAVIOUR	Appropriate ☐	Inappropriate (Comment): ☐	

COMMUNICATION

☐ English is spoken and understood ☐ Other Language:

Communication barriers:

SOCIAL INFORMATION

Support System / Network:

If currently hospitalized - has the option of discharge home been explored? Yes ☐ No ☐

Barriers to discharge home are:

Patient and family are aware of referral to Palliative Care Program? Yes ☐ No ☐

Is client / family in agreement with referral to a Palliative Care Consult if needed? Yes ☐ No ☐

The Following Documentation Must Be Completed By A Physician or Nurse Practitioner

Completion of this form does not mean patients will be registered on the WRHA Palliative Care Program. After the information on this form has been reviewed, you will be notified in writing regarding acceptance for registration on the WRHA Palliative Care Program.

Discussion regarding "End of Life" care wishes and expectations is a natural and important component of the process of initiating a application for registering on the Palliative Care. The application usually reflects a transition in focus of care and in hoped-for outcomes. Such discussions are best undertaken by the health care providers with whom a relationship has already been established; this would usually be the referring physician or nurse practitioner.

Registration on the WRHA Palliative Care Program requires that the patient (or family, if the patient is not competent) is not expecting attempted resuscitation in the event of the cessation of cardiac and/or pulmonary function. Patients should not be undergoing or planning a course of treatment with expectations of monitoring for and intervening for complications in a manner other than comfort-focused (this usually refers to chemotherapy).

Acceptance of "Do Not Attempt Resuscitation" (DNAR) by patient (or family if patient not competent)? Yes ☐ No ☐

The following issues have been discussed:

1. Does the patient have a Health Care Directive ("Living Will") or Advance Care Plan? Yes ☐ No ☐
2. If "No", has this been discussed? Yes ☐ No ☐
   Has there been discussion of treatment issues related to end of life care? Yes ☐ No ☐
   (antibiotic use, blood transfusions, fluids, etc)
3. Has the patient been informed of diagnosis and prognosis? Yes ☐ No ☐
   If "No", please explain:
4. Has the family been informed of diagnosis and prognosis? Yes ☐ No ☐
   If "No", please explain:
   Other comments:

Physician / Nurse Practitioner Follow-Up:

1. The Palliative Care Drug Access Form has been completed and is included with application for registration Yes ☐ No ☐
2. Will you accept consultation by a Palliative Care Physician Consultant if indicated? Yes ☐ No ☐
3. Is the Primary Care Provider aware of referral? Yes ☐ No ☐
4. Will you continue to be the Primary Care Provider while the patient is out of the hospital? Yes ☐ No ☐
5. Will you continue to be involved in the patient's care? Yes ☐ No ☐
6. If you will not be the Primary Care Provider, who will? Name: Telephone:

Physician's or Nurse Practitioner's Signature:	**Name (Please print):**	**Date:**

FOR OFFICE USE ONLY:

Accepted: ☐ **Pending:** ☐ **Rejected:** ☐ **Date:** ____________

Explanation (Pending / Rejected):