GRAND RIVER HOSPITAL **Freeport Health Centre**

ADMISSION APPLICATION: PALLIATIVE CARE/HOSPICE UNIT

Client's Name: ________________________________ **POA?** ☐ no ☐ yes- detail : ____________________

Diagnosis:

Requesting admission for: ☐ End of Life ☐ Symptom Management ☐ Other ______________________

Required information:

Anticipated Prognosis (in months or weeks): ____________________

PSM consult date : ______________________________

Advanced Directives detail**:** ________________________

Are symptoms controlled? (please include ESAS) ☐ yes ☐ no-describe: ______________________________

____

PPS score as of the date of application: __________________________

Last known PPS score: _____________ date: ________________________

Is PPS stable? ☐ yes ☐ no-describe : ____

Is the patient aware that he/she is coming for palliative treatment/placement? ☐ yes ☐ no

SPECIAL CONSIDERATIONS

Psychosocial needs:

Cognitive Change: ☐ no ☐ yes-describe: ____

____

Spiritual /Emotional distress: ☐ no ☐ yes-describe: ____

____

Other: ____

Equipment needs:

☐ central line detail:_________________ ☐ peripheral IV ☐ suction ☐ pain pump ☐ NG tube

☐ tenchkoff detail:__________________ ☐ O2 detail___________ ☐ chest tube ☐ other_____________

Treatment needs:

☐ Wound care (attach details) ☐ Thoracentesis ☐ Paracentesis ☐ Transfusion details: _______________

☐ TNA ☐ Enteral Feeds ☐ Other :________________________

Planning issues:

☐ Outstanding appts:____

☐ Family Support Needs:____

☐ Other: ____

GRAND RIVER HOSPITAL

Freeport Health Centre

ADMISSION APPLICATION: DEMOGRAPHIC INFORMATION

PATIENT'S PERSONAL INFORMATION

Last name	First name	❒ Male ❒ Female

Address	Apt. #	City	Prov.	Postal code

Home telephone	Present location

Date of birth year / month / day	Age	❒ Single ❒ Married ❒ Widowed ❒ Divorced

Religion	Place of worship

Family physician	Phone Fax	Most Responsible Physician	Phone Fax

HEALTH INSURANCE INFORMATION

Is patient covered under Ontario Health Insurance Plan? ❒ No ❒ Yes Last name on Health Card:__	Health Insurance Number	Version code
Accommodation preferred ❒ Ward ❒ Semi-private ❒ Private	Insurance attached ❒ No ❒ Yes	

EMERGENCY CONTACT INFORMATION

Next of kin/primary contact	Relationship

Address	City	Prov.	Postal code

Telephone (home)	Telephone (work)	Ext.

Power of Attorney	❒ Personal care Name:	❒ Financial Name:

Substitute Decision Maker

CLINICAL INFORMATION

Diagnosis

Infections MRSA ❒ No ❒ Yes VRE ❒ No ❒ Yes Other—specify

Allergies ❒ No ❒ Yes Specify (attach sheet if necessary)	Diabetic ❒ No ❒ Yes

REFERRAL SOURCE

Facility	Date year / month / day

Contact person	Phone	Pager	Fax
Alternate contact	Phone	Pager	Fax

INTERNAL — FREEPORT HEALTH CENTRE USE

Expected date of admission year / month / day	**REH** ❒ GNR ❒ DER ❒ GER ❒ PUL	**CHR** ❒ PAL ❒ ASE ❒ RET ❒ FEU
Actual date of admission year / month / day	Bed confirmed	

Notes

Attending physician	Bed assigned

GRH2119 (01-01)

Freeport Application Process for Palliative Care and Hospice:

Please complete this form as thoroughly as possible. The information that is provided will help ensure that the right patient gets to the right bed in the right period of time.

All referrals must have a Palliative Care Consultation prior to completing application.

Freeport Application Checklist:
(please include if not available electronically)

☐ History and Physical

☐ Consultation Notes

☐ Palliative Care Consultation Note

☐ Pertinent Diagnostic Tests

☐ MAR – Most current medication records

☐ Progress Notes

☐ ESAS

☐ PPS

Referral Source:

Name: ________________________________Tel:_______________Date:_______

Discipline: _____________________________

For internal use only:

Date application received:______________________ initials :__________

Date application accepted:______________________ initials:__________