OTTAWA SOUTH
PALLIATIVE GROUP

FAX: 613-212-2238

REFERRING PHYSICIAN	PATIENT INFORMATION
Physician Name	*Patient Name*
Billing Number	*Date of Birth* (mm/dd/yyyy) ____ / ____ / _____
Phone (direct/private #)	*Gender* ☐MALE ☐FEMALE
PATIENT CONTACT	
ADDRESS WHERE PALLIATIVE CARE IS TO BE PROVIDED _____ *Address* _____ _____ *Apt #* *Postal Code*	*Telephone numbers* *Home:* _____ *Other:* _____
Health Card Number _____	*Version Code* _____ *Expiry Date* _____
CAREGIVER INFORMATION	
Name of main support person	*Contact number for main support person*
PATIENT SUPPORT AND SERVICES	
CCAC Case Manager/Retirement home director of care	*Supports at home:*
	Family MD:

PATIENT MEDICAL STATUS AT TIME OF REFERRAL		
Goals of care (CPR/transport to ED)	*Urgency of referral (1-2 days vs 1-2 weeks)*	*DNR* ☐YES ☐NO
PPS and ECOG	*Life limiting illness*	*Date of onset*
Anticipated prognosis	*Metastatic sites*	*Comorbidities*
Current symptoms/ disease complications		*Additional Info*