

Are you a health care professional who cares for palliative patients and needs support?

The Champlain Regional Palliative Consultation Team (RPCT) is here for you.

The RPCT is a partnership between Bruyère Continuing Care and Ontario Health atHome. We are a team of inter-professional palliative-care experts, including nurse practitioners, advanced practice nurses, nurse specialists and doctors.

Referral Criteria

To access our support, your patient must:

- 1) Have a life-limiting illness that is actively progressing, and requires assistance with one or more of the following:
 - Management of symptom(s) caused by the underlying life-limiting illness.
 - Decision-making or goals of care conversations is needed (these conversations have been initiated or primary care provider is willing to be present)
 - Complex end-of-life care.
- 2) Be receiving nursing services from Ontario Health atHome (or a referral has been sent) or has access to around-the-clock nursing care through their facility or other home-care program.
- 3) Have a primary care provider who will continue as the most responsible provider and remain in regular contact.

The provider needs to be available by phone to RPCT consultants for after-hours emergencies only and will be responsible for completing the medical certificate of death when the time comes.

RPCT can be involved if the primary care provider does not provide home visits, as long as they remain closely involved in the care of the patient.

Champlain

Regional Palliative
Consultation Team



Équipe régionale
de consultation en
soins palliatifs

de Champlain

We offer health care professionals palliative-care expertise, including:

- ➔ 24 / 7 specialist-level consultation
- ➔ Collaborative support in complex symptom management and end-of-life care
- ➔ Advanced palliative care education, coaching and mentoring.

- ✓ Ensure all sections are complete **before** you fax the referral. We return incomplete referrals, which delays the triage process.
- ✓ If you need immediate assistance, please call us after you fax the completed referral.
- ✓ Our response time may vary: please call us if your patient needs an immediate assessment, or if you would like advice by phone to manage the situation - **we are available 24 / 7**

Patient name				DOB	
Facility name (if applicable)					
Street address				Apt / Unit / Room	
City		Postal Code		Phone	
Health Card	OHIP			VC	
<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify)				Needs language interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (specify)					

Primary Care Provider (PCP) following this patient in the community.

Name			Billing # (if known)	
Office Tel		Private line		Fax
After-hours / Mobile *only for use by RPCT*				

Referring Professional: Are you the PCP? Yes No

PCP: Please skip the rest of this section and go to **Patient's Home-Care Services Status**, below.

Name			Organization	
Phone			Fax	
PCP is aware of referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Your role?	<input type="checkbox"/> PCP office		<input type="checkbox"/> Care Coordinator	<input type="checkbox"/> Service provider organization
Location	<input type="checkbox"/> Hospital (specify)		<input type="checkbox"/> Hospice (specify)	
	<input type="checkbox"/> Retirement / Group home		<input type="checkbox"/> Other (specify)	
<input type="checkbox"/> LTCH				

Patient's Home-Care Services Status

Home-care referral submitted or already receiving home-care services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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Referral Form

613.562.6397, or toll-free 1.800.651.1139

Fax: 613.562.6394, or toll-free 1.844.689.1768

Patient Name _____ DOB _____

Diagnosis/es (check all that apply)

<input type="checkbox"/> Cancer	Primary Site				
	Metastatic Site(s)				
<input type="checkbox"/> Advanced end-stage organ failure	<input type="checkbox"/> Lung	<input type="checkbox"/> Heart	<input type="checkbox"/> Renal	<input type="checkbox"/> Liver	
<input type="checkbox"/> Neuro-degenerative	<input type="checkbox"/> ALS <input type="checkbox"/> Parkinson's <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other (specify)				
<input type="checkbox"/> Dementia/Frailty					
<input type="checkbox"/> Other (specify):					

Additional Information

Palliative Performance Scale	%	Deterioration Rate	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Estimated prognosis	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months	<input type="checkbox"/> Years	<input type="checkbox"/> Unknown

Reason(s) for Consultation

<input type="checkbox"/> Palliative symptoms (check all that apply)	<input type="checkbox"/> Pain	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Nausea / vomiting	<input type="checkbox"/> Delirium
	<input type="checkbox"/> Other(s) (specify)			
<input type="checkbox"/> End-of-Life Care	For actively dying patients, ensure home-care support is in place, or call us to discuss.			
<input type="checkbox"/> Conversations about decision-making and / or goals of care	Have conversations been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "no" or "unknown": note if this is the only reason for consultation, we will ask the PCP to be present during the initial conversation.			

Pt / Caregiver Awareness & Other Palliative-Care Information

Are they aware of diagnosis/es and prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Are they aware of RPCT referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pt currently followed by another palliative-care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred to another palliative-care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Comments / Concerns / Information