GREATER TRAIL HOSPICE SOCIETY

Phone: (250) 364-6204 **Fax**: (250) 364-6218
Kiro Wellness Center, Suite 7- 1500 Columbia Ave, Trail, BC, V1R 1J9

Hospice Referral Form

CLIENT NAME: _____ Prefers to be called: _____

Birth Date: _____ Age: _____ Marital Status: _____

Address: _____ City: _____

Phone: _____ Postal code: _____

Current Location:
- ☐ Acute Care, Ward: _____
- ☐ CVL ☐ Poplar Ridge ☐ Rosewood Room #: _____Bed#_____
- ☐ Home (at address above)
- ☐ Other: _____

Diagnosis: _____

Palliative Performance Scale: _____% **CPR Directive or DNR form signed:** ☐ Yes ☐ No

Are client and/or family aware of this referral? ☐ Yes ☐ No

Special Precautions, (e.g. infection control issues; mobility issues, pets in home, allergies, etc).

_____

Contact Information

Primary Contact: _____ Relationship: _____

Phone: Home/Cell/Work _____

Secondary Contact: _____ Relationship: _____

Phone: Home/Cell/Work _____

Referral Requested ☐ **Urgent** (1-2 days) ☐ **Non-urgent** (3-14 days)

- ☐ Assessment of client & family needs
- ☐ Education about resources for client/family
- ☐ Bedside Volunteer(*fill out other side)
- ☐ Other: _____

Date of Referral: _____ Phone Number: _____

Source of Referral (Name of Person making referral): _____

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CLIENT NAME: _____

(Please fill out the information on the other side of this form)

Information that will help us care for this client more personally (eg. likes/dislikes, family life, career, faith preferences, personal interests, etc.):

_____

_____

_____

_____

_____

_____

Does this person like music? ☐ Yes ☐ No. If yes, what type? _____

Does this person like reading? ☐ Yes ☐ No. If yes, what type? _____

(e.g. poetry, Scripture, other)

What else would bring comfort to this person? (Hobbies /interests? Relaxation techniques?)

_____

_____

_____

_____

Intake Notes:

H.A.R.P. home safety form complete: ☐ Yes ☐ No Type of Assessment done: _____

By: _____ Date: _____

Comments: _____

_____

_____

_____

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