REFERRAL FOR PEDIATRIC PALLIATIVE CARE CONSULTATION

□ FAX: (519) 749-4206 Grand River Hospital Children's Outpatient Clinic

□ FAX: (519) 578-9750 Community HPC Team (NP)

***Please note: A referral for pediatric palliative consultation must include a CCAC referral for nursing, if patient not already on services*.**

Name:_____ Date of Birth: _____Language:_____
Address:_____HIN:_____Version:_____
_____Phone:_____
Alternate Contact:_____Relationship:_____
Phone: _____ Use Alternate Contact for Communication? Yes □ No □

Referring Physician: _____Phone: _____Back Line_____
Family Physician: _____Phone: _____Back Line_____
Has patient been seen at a Tertiary Centre? Yes □ No □ Which Centre? _____
Oncologist or Specialists_____

Has a CCAC referral been made or is patient receiving CCAC services?	**Yes □**	**No □**
Is the family physician aware of this referral? (if referred by specialist)	**Yes □**	**No □**
Is the patient aware of this referral?	**Yes □**	**No □**
Can the patient attend physician's office?	**Yes □**	**No □**
Has patient/parents given consent to release medical information to this service?	**Yes □**	**No □**

Urgency of Referral: **Within 1 week □ 1- 2 weeks □ 2- 4 weeks □**

Diagnosis and Reason for Referral:

Date of diagnosis. Specific Pain or Symptom management challenges / Psychosocial issues.
Copies of consultations, diagnostic tests, pathology reports, and imaging reports must be sent with this referral.

Concurrent Illnesses / Relevant Past Medical History:

Current Medications with known allergies:

Other Comments:

Signature_____ Telephone _____ Date: _____