



## Referral to UOHI Cardiac Supportive and Palliative Care Program

Reasons for referral may include:

- Symptom management
- Advance care planning/goals of care discussion
- Emotional support/coping with life-threatening illness
- Community care referral and coordination
- Caregiver support

**For hospital inpatients, consider phone contact between attending physician or palliative care physician and UOHI CSPCP early in the discharge planning process. If this referral is urgent (first consult required within one week), please contact the program to confirm availability- 613-696-7000 x 14188.**

Completed form should be faxed to 613-696-7138 or emailed to [supportivecare@ottawaheart.ca](mailto:supportivecare@ottawaheart.ca).

### Please attach most recent:

- Bloodwork
- Chest imaging
- Cardiac investigations
- Specialist consult note(s)
- Hospital notes

Patient Name:

Date of birth:

Gender:

Age:

Health Card Number:

Address:

City:

Prov.:

Postal Code:

Phone number (home):

Phone number (cell):

Referral Name:

Address:

City:

Prov.:

Postal Code:

Billing Number:

CPSO:

Phone Number:

Fax Number:

Date of Request:

Primary Care Provider:

Address:

City:

Prov.:

Postal Code:

Phone Number:

Fax Number:

## Reason for Referral \*

Select all that apply:

- Symptom management
- Advance care planning/Goals of care discussion
- Emotional support/coping with life-threatening illness
- Community care referral and coordination
- Caregiver support
- Other

## End Stage Cardiac Diagnosis

**Please provide as much information as possible.**

Date of original diagnosis:

NYHA Class:

- No symptoms nor limitations in ordinary activity
- Mild symptoms and slight limitation in activity
- Marked limitation with even normal activity
- Severely limited, symptoms at rest, mostly bedbound

LV Ejection Fraction, if known:

Please check all that apply:

- More than two CHF hospitalizations in last 12 months
- Systolic BP < 100
- Heart rate > 100
- Renal dysfunction
- Hyponatremia
- Orthopnea
- Cognitive impairment
- Fatigue
- Ascites
- Pleural effusion
- Cachexia
- Syncope

Implanted cardioverter/defibrillator:

No

Yes

## Advanced Directives and Planning

Advanced Directives and Planning

Yes

No

Not sure

## Patient/Caregiver Awareness

Is patient and/or caregiver aware that this referral is being made:

Yes

No

## Current Location of Patient

Home

Hospital

Retirement Home

## Location of Care

Where will Palliative Care be delivered:

Same as current home address

Moving to different location:

## Participants in Care

Does patient live alone:

Yes

No

Language:

English

French

Other

Main caregiver name:

Main caregiver phone number:

Same as patient

Other

Relationship of main caregiver to patient:

Power of Attorney for Personal Care:

Same as main caregiver

Other

Other physicians involved in this patient's care: