Last Name ______________________ First Name ____________________

PIN _______________________________ Gender ___________________

Address ____

____

DOB __________________________ Home Phone ___________________

Work Phone __________________________ Cell ____________________

Palliative and End of Life Care (PEOLC) Navigator Referral Form

Phone: 780.608.4927
Fax: 780.608.4931

Date of Referral ___________________________

Referring Physician/Healthcare Provider__________________________ Phone _____________Fax _________________

Date of next follow-up appointment with Physician (if any) ____

Urgency of response ☐ Urgent (1-2 business days) ☐ Non-urgent (1-2 weeks)

Reason for Referral (Patient/Family/Caregiver may need help finding support(s) for…)

☐ AHS Palliative Assessment/Symptom Control ☐ AHS Home Care

☐ Grief and Bereavement ☐ Other ____

Is the patient/guardian aware of this referral and given consent ☐ Yes ☐ No

Is this patient a home care client? ☐ Yes ☐ No

Patient Diagnosis ____

Is the patient/guardian aware of Diagnosis ☐ Yes ☐ No

Patient's Current Location ☐ Home ☐ Lodge ☐ DSL ☐ Continuing Care ☐ Hospital

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Goals of Care completed ☐ Yes ☐ No ☐ Partial

Next of Kin______________________________________ Contact Information____

Personal Directive/Guardianship ☐ Yes ☐ No ☐ Enacted

Name____

Contact Info ____

Details of social situation/ identified needs/concerns:

Revised Sept 2018