Alberta Health Services

Palliative Care Consult Service - Rural
Consult Request

Patient Name	Date of Birth (yyyy/mon/dd)	Age

Gender: ☐ Male ☐ Female	PHN #	PARIS #

Patient Residence	**Directions to Residence**
Street: _____	_____
Community: _____	_____
Province: _____	_____
Postal Code: _____	_____
Telephone: _____	_____

Patient's Current Location

Care setting: ☐ Home ☐ Acute Care ☐ Long Term Care ☐ Other: _____

Community:

☐ Airdrie	☐ Canmore	☐ Claresholm	☐ High River	☐ Strathmore
☐ Banff	☐ Carmangay	☐ Cochrane	☐ Nanton	☐ Vulcan
☐ Black Diamond	☐ Chestermere	☐ Didsbury	☐ Okotoks	☐ Other: _____

Consult Request

From:

Name: _____ Discipline/Position: _____ Phone: _____ Date: (yyyy/mon/dd)

Has the patient's physician requested/agreed to palliative consult for this patient? ☐ Yes ☐ No _____

Is the patient aware of this consult request? ☐ Yes ☐ No _____

Reason for consult:

- ☐ Complex pain and symptoms
- ☐ Psychosocial or spiritual distress for person or family
- ☐ Difficult end of life decision making
- ☐ Transition to alternate settings of care (i.e. hospital, hospice, home)
- ☐ Deteriorating physical or cognitive function
- ☐ Education needs of the person or family
- ☐ Coordination of resources

Comments:

The Rural Palliative Consult Team will contact the referring source within 3 business days of receiving the consult request to schedule a consultation visit.

If consult requests are urgent, the patient's physician can obtain immediate phone advice from a Palliative Care Physician Consultant by contacting RAAPID at 403-944-4486

Diagnosis

Primary: ☐ Cancer: _____ Metastases: _____

Primary: ☐ Non-Cancer: _____ Co-Morbidities: _____

Family Physician	**Consultants**	**Home Care**	**Pharmacy**
_____ *(Name)*	_____	☐ Yes ☐ No	_____ *(Name)*
Phone: _____	_____	_____ *(Coordinator's Name)*	Phone: _____
Pager/Cell: _____	_____	Phone: _____	Fax: _____
_____ Fax: _____	_____ *(name and specialty)*		

Fax completed form (2 pages) to 403-776-3841 Phone: 403-995-2714

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Consult Request

Patient Name	PHN #

Medical History

Lab Results / Diagnostic Tests

Medications

Allergies

Care Needs

Dressings: _____

Tubes / Drains: _____

Stomas: _____

Oxygen: ☐ No ☐ Yes _____ LPM

Other care needs: _____

End of Life Decision Making

GCD Order: ☐ No ☐ Yes Order: _____

Personal Directive: ☐ No ☐ Yes

Date of directive: _____

Agent: _____

Other: (e.g. POA) _____

Financial

☐ Blue Cross

☐ AISH

☐ DVA

☐ Other: _____

Type of Residence

☐ DAL / PAL

☐ Group home

☐ Lodge

☐ Personal care home

☐ Private home

☐ Care centre

Lives With

☐ No one (alone)

☐ Spouse

☐ Spouse & others

☐ Other family

☐ Others only

Marital Status

☐ Single

☐ Married (include. C / L)

☐ Separated

☐ Divorced

☐ Widowed

Date widowed: _____

Language

Language spoken: *(if not English)*

Interpreter required:

☐ Yes ☐ No

Occupation

Other Psychosocial Considerations

Ethnocultural / Religious Considerations

Primary Support / Contact People

Name	Relationship	Address	Contact Numbers

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