Alberta Health Services

Palliative Care Consult Team Referral

For more information on criteria and where to send the referral visit:
www.albertareferraldirectory.ca

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)	

Date *(dd-Mon-yyyy)*	Client Phone
Service Address *(where care will be provided)*	
Residence Type ☐ Home ☐ Acute Care ☐ Type A ☐ Type B ☐ Other *(specify)* _____	
Client Mailing Address	☐ Same as above
Resident of Alberta ☐ Yes ☐ No	

Referring Provider/Source	Phone	Fax
Primary Care Provider		Phone
Is Primary Care Provider informed of referral? ☐ Yes ☐ No		
Emergency Contact	Phone	Relationship
Is Client aware and in agreement with the referral? ☐ Yes ☐ No If no, specify _____		
Residence Site *(if applicable)*		
Functional status ☐ fully independent ☐ partial or/stand by assist ☐ one or/two person assist ☐ total care		
Palliative Performance Scale (PPS) *(If known)*		
Advance Care Planning Goals of Care Designation (GCD) ☐ Yes ☐ No *(if yes, specify type)* ☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2 ☐ C1 ☐ C2		

Referral Type

Priority of Referral ☐ Routine ☐ Urgent ☐ Emergent
Primary Palliative Diagnosis *(cancer and non-cancer)* and relevant health conditions

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Reason for Referral *(check all that apply)*

- ☐ Symptom Management
- ☐ Advance Care Planning / Goals of Care Designation (ACP/GCD) Conversation
- ☐ Deteriorating physical or cognitive function
- ☐ Family support/respite
- ☐ Psychosocial distress for person or family
- ☐ Education needs of the person or family
- ☐ Hospice assessment/transition
- ☐ Other *(specify)* _____

Current Concerns

Symptom Issues/Needs *(check all that apply)*

☐ Pain	☐ Nausea/vomiting	☐ Constipation	☐ Confusion/delirium
☐ Excessive drowsiness	☐ Shortness of breath	☐ Fatigue	☐ Loss of appetite
☐ Anxiety	☐ Depression related to palliative or end-of-life diagnosis		

☐ Other *(specify)* _____

Special Considerations *(e.g. economic, interpreter required, accessibility issues, etc.)*

Is Client/Family aware of diagnosis/prognosis ☐ Yes ☐ No

If no, specify _____

Completed By

Name	Signature	Designation	Date *(dd-Mon-yyyy)*