Yukon

PALLIATIVE CARE RESOURCE TEAM

CONSULT REQUEST FORM

Client name		Date of birth YYYY/MM/DD	Health care number
Home address			Phone
Gender ☐ Female ☐ Male ☐ Other	Language	First Nation	Status number
Emergency contact		Relationship	Phone
Family doctor			

Diagnoses:

Is the client aware of their disease status and prognosis? ☐ Yes ☐ No

Has an Advance Directive been completed? ☐ Yes ☐ No

Current location of care: ☐ Hospital ☐ Home ☐ Residential Care Setting ☐ Other: _____

If in hospital, projected discharge date/location:_____

Allergies:

Palliative Performance Scale (if known): _____%

Attach medication list and relevant health history.

Funding agencies: ☐ Private insurance ☐ WCB ☐ Veteran Affairs ☐ Other: _____

Reason for referral (completed by referral source):

Is the client aware of and in agreement with a referral to the palliative care program? ☐ Yes ☐ No

Form completed by (print name)	Agency
Date of referral YYYY/MM/DD	Phone/email

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