

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Healthcard # \_\_\_\_\_ V.C. \_\_\_\_\_

Sex:  Male  Female

**APPLICATION FOR BEDDED  
HOSPICE/PALLIATIVE CARE**

Preferred Location:

- The Hospice of Windsor Essex (Windsor Location)
- The Hospice of Windsor Essex (Leamington Location)
- Community Care Access Centre
- Hotel-Dieu Grace Healthcare
- 1<sup>st</sup> Available Bed

Current Location of Patient: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_ Prognosis: \_\_\_\_\_

Prior Hospice/Palliative Care Physician: \_\_\_\_\_

Safety Concerns: \_\_\_\_\_

Restraints:  Yes  No Cognitive Status:  Alert & Orientated  Confusion  Delirium  Agitation

Behaviour Concerns: \_\_\_\_\_

Family Support: \_\_\_\_\_

Patient/Family Issue: \_\_\_\_\_

Psychosocial Concerns: \_\_\_\_\_

Other Issues/Concerns: \_\_\_\_\_

MRSA  VRE  C.Diff Other: \_\_\_\_\_

**ESAS Score:**

Pain: \_\_\_\_\_ Tired: \_\_\_\_\_ Nausea: \_\_\_\_\_ Depression: \_\_\_\_\_ Anxiety: \_\_\_\_\_ Drowsiness: \_\_\_\_\_

Appetite: \_\_\_\_\_ Wellbeing: \_\_\_\_\_ Breathlessness: \_\_\_\_\_ Bowels: \_\_\_\_\_ Other: \_\_\_\_\_

PPS: \_\_\_\_\_ DNR Status: \_\_\_\_\_ DNR-C:  Yes  No HPP:  Yes  No PCCR:  Yes  No

Pain and Symptom Management Concerns: \_\_\_\_\_

Pain Pump  Methadone  Medical Marijuana

**Treatment Required:**

DIET: \_\_\_\_\_ WT: \_\_\_\_\_ kg HT: \_\_\_\_\_ cm

TNA  Tube Feed Formula: \_\_\_\_\_ Rate: \_\_\_\_\_ Flush Frequency: \_\_\_\_\_

Denver Pleurx How Often? \_\_\_\_\_  Paracentesis How Often? \_\_\_\_\_

Radiation: \_\_\_\_\_  Chemotherapy: \_\_\_\_\_

Hgb: \_\_\_\_\_  Blood Transfusion: Frequency: \_\_\_\_\_ Last Date: \_\_\_\_\_

OT  PT: Weight Bearing Status: \_\_\_\_\_

Dialysis: Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Last Date: \_\_\_\_\_

IV Type of Line(s): \_\_\_\_\_  O<sub>2</sub> Flow Rate: \_\_\_\_\_ Vendor: \_\_\_\_\_

Ventilator: \_\_\_\_\_  Trach Care: \_\_\_\_\_

**Skin Integrity:**  Ulcers/Wounds: Type: \_\_\_\_\_ Location: \_\_\_\_\_ Size & Depth: \_\_\_\_\_

Stage: \_\_\_\_\_

Treatment: \_\_\_\_\_

Therapeutic Mattress: Type: \_\_\_\_\_

N.B.: Other Required Information: (1) Med List (2) MUR (3) H&P (4) Consults (5) Discharge Summary  
Information gathered from the following sources: \_\_\_\_\_

Signature/Title & Contact Phone # \_\_\_\_\_

Print Name \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_