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

Current Location of Patient: ________________________________

Reason for Admission: ________________________________

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:


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): ________ [ ] O2 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) ________________________________