Vancouver CoastalHealth
Promoting wellness. Ensuring care.

North Shore Hospice – Day Program
Referral

Fax to: 604-984-3798

NORTH SHORE HOSPICE

Date Referred:_____

Referred BY_____Designation_____Phone:_____Fax:_____

Patient Name_____ DOB:_____Gender: F / M

Home Phone _____Cell Phone:_____

Patient's Address:_____

Next Of Kin Name _____ Relationship to Patient _____

Address _____ Phone: _____ Cell: _____

PHN :_____

Patient aware of full diagnosis & prognosis? **Yes / NO**

For Urgent Referrals (see within 1 week):
the referring clinician should call the Palliative Care Liaison Nurse (778 828 8100)

Reason for Referral _____
(attach related medical records or dictated summary)

☐ Please advise on the patient's care ☐ Please assume care of this patient

☐ **Mobility**

- o Full/independent
- o Uses mobility aids (please state) _____
- o Wheelchair dependent

☐ **Medications and Dosages tried and outcomes**
Please ask patient to bring a complete medication list with dosages (or bring the meds) to their first visit.

Any other issues or concerns? _____

Office Use Only

Date of preliminary assessment:_____PLN _____

Date of 1st visit _____

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