Revised December 2006

REFERRAL FOR PEDIATRIC PALLIATIVE CONSULTATION

C/O Grand River Hospital Children's Outpatient Clinic Phone: 519-749-4300 x 5590

PLEASE FAX TO: (519) 749-4206

Please note: A referral for pediatric palliative consultation must include a CCAC referral for nursing, if patient not already on services.

Name:___________________________________ Date of Birth: __________Language:__________
Address:________________________________HIN:______________________Version:______
____Phone:__________________________________
Alternate Contact:__________________________________Relationship:________________
Phone: ________________ Use Alternate Contact for Communication? Yes □ No □

Referring Physician: __________________________Phone: _____________Back Line__________
Family Physician: ____________________________Phone: ______________Back Line_________
Has patient been seen at a Tertiary Centre? Yes □ No □ Which Centre? __________________
Oncologist or Specialists____

Has a CCAC referral been made or is patient receiving CCAC services? Yes □ No □
Is the family physician aware of this referral? (if referred by specialist) Yes □ No □
Is the patient aware of this referral? Yes □ No □
Can the patient attend physician's office? Yes □ No □
Has patient/parents given consent to release medical information to this service? Yes □ No □

Urgency of Referral: **Within 1 week □ 1- 2 weeks □ 2- 4 weeks □**

Diagnosis and Reason for Referral:

Date of diagnosis. Specific Pain or Symptom management challenges / Psychosocial issues.
Copies of consultations, diagnostic tests, pathology reports, and imaging reports must be sent with this referral.

Concurrent Illnesses / Relevant Past Medical History:

Current Medications with known allergies:

Other Comments:

Signature___________________________ Telephone ______________ Date: ___________