REFERENCE FORM - Palliative Care / In-Home Respite Program

Referral to NOVA Montréal Inc. Requested by:________________________ Department:__________________________ Phone:( ) _________________________	Surname:____________________________ Name: ______________________________ Address: ____________________________ __________________________________ Postal Code:_________________________ Date of birth:________________________ Gender: ____________________________ Medicare No:_________________________

Support System (other than caregiver)
Family or significant person: ____
TEL Home: ________________Cell: __________________ Office:_______________

Name of caregiver:____
TEL Home: ______________ Cell: __________________ Office: _______________
Language: ________________ Age: __________Number of work hours per week:________

Reason for request: ____
____
____
____
____

Primary diagnosis (date): __________________________
____
____
Infectious disease (precautions):___________________
____
Related diagnosis / services received (dates):
____
____
____
____

Current Medication
(attach list if necessary)
____
____
____
____
____
____
____
____

Medical follow-up:
____
Tel. (   ) __________________ Fax (   ) _________________ Pager: _________________
Hospital Name / Address:
____

Allergies:____

CLSC / others implicated: ____
Tel. (   ) _______________ Fax (   ) _______________ Pager _______________
Tel. (   ) _______________ Fax (   ) _______________ Pager _______________
Tel. (   ) _______________ Fax (   ) _______________ Pager _______________

Health Problems Physical / Functional Capacity
Inability: Mobility ☐ Behavior ☐ Continence ☐ Communication ☐
Mental status ☐ Motivation ☐ Management of medication ☐
Identified hazards ☐
Other relevant issues:
____
____
____
____

Supplies / Equipment :
____

Situation/ Family Support Issues
Specifics: ____
____
____
____

Description of the network support and services (neighbours, organizations):
____
____
____

Other information i.e. references in progress, pre-admission in palliative care
____
____
____

Other professionals implicated (name and profession)
_____________________________________ Tel.:_____________________
_____________________________________ Tel.:_____________________

Client agrees to reference and transmission info ☐

Financial capacity (approx.)
Annual household income < $25,000 ☐ ≥ $25,000 - $40,000 ☐ >$40,000 ☐
Comments:____
____
____

Name: ________________________ Signature: ________________________

Date: ________________________ March, 00, Sept 06, Oct.10, May 12,Aug.13, Sept.14