MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Outpatient Palliative Care Clinic Referral Form

825 Coxwell Ave. Toronto, ON M4C 3E7   Tel: 416-469-6580 ext. 2847   Fax: 647-480-6313

DATE: ____

1. Patient Demographics

Name: ____

DoB: ____

OHIP #: ____

Address: ____

Phone Number(s): ____

2. Referring Physician Information

Name: ____

CPSO#: ____

Billing Number: ____

Phone Number(s): ____

Reason for referral (please check all that apply):

☐ Symptom management

☐ Pain ☐ Shortness of breath ☐ Nausea/vomiting ☐ Anxiety ☐ Loss of appetite

☐ Supports needed related to:

☐ Nephrology ☐ Oncology ☐ Respirology ☐ Other: ______________________

☐ Advance Care Planning

☐ Other: ____

3. Code status

☐ Full Code

☐ DNR

☐ Have not discussed

4. Goals for consult

☐ Consult only

☐ Consult + primary management of palliative care needs

★★★ **Please attach most recent clinical notes**

Referral Criteria

Life Expectancy <24 months + chronic disease/terminal illness

Patient resides in East York or Scarborough