Bethell Hospice
HILLS of HEADWATERS COLLABORATIVE
ONTARIO HEALTH TEAM

REFERRAL FORM
Palliative Care Physician Connect - PCPC
to Bethell Hospice Community Physicians

15835 McLaughlin Road, Inglewood, ON L7C 1H4

FAX this form and supporting documents to 905.838.0302

Your submission of this form will be taken to explicitly mean that the patient has given their permission to make the referral and to disclose appropriate personal health information for initiating the services of our Bethell Hospice (BH) palliative care physicians.

Referral ELIGIBILITY:

□ Patient has prognosis of less than 6 months with PPS ≤ 60%. □ Patient is connected to home care services through Ontario Health at Home – Central West. If not, please initiate. □ Patient lives in catchment area of Dufferin-Caledon (refer to the map). □ Referral is NOT solely for MAiD provision.	□ Referral source (or Family Physician) remains MRP until patient is seen and accepted by BH Community Physicians. □ Referral source (or Family Physician) agrees to resume MRP status if patient improves and no longer meets referral criteria. □ All physicians agree to stop billing G512 code once patient accepted to BH Community Physician team.

DATE of Referral: _____

Reasons for Referral / Goals of Care (if known):

REASONS for Referral:	**URGENCY:**
□ Shared care (details to be discussed between the Family MD and the Palliative MD)	☐ urgent (within 7 business days) ☐ semi-urgent (within 14 business days) ☐ non-urgent (within 21 business days)
□ Transfer of care to Bethell Hospice Community Physicians (PPS ≤ 60% and less than 6 months prognosis)	☐ urgent (within 7 business days) ☐ semi-urgent (within 14 business days) ☐ non-urgent (within 21 business days)
□ Referral to Bethell Hospice Community Support Program (psychosocial support, caregiver support)	☐ urgent (within 7 business days) ☐ semi-urgent (within 14 business days) ☐ non-urgent (within 21 business days)

PATIENT Information:

LAST Name: _____ FIRST Name: _____

Date of BIRTH: _____ HEALTH Card #: _____ VC: _____

Address: _____ Apt #: _____ Entry Code: _____

City: _____ Postal Code: _____

Telephone # (preferred): _____ Alternate #: _____

Current LOCATION:

☐ Home ☐ Retirement Home ☐ Hospital_____ Anticipated Discharge Date: _____

☐ Lives alone ☐ Young children in the home ☐ Smoking in the home ☐ Pets in the home

PRIMARY Palliative Diagnosis:	
DATE of Diagnosis:	
If CANCER Diagnosis:	Metastatic spread: ☐ Yes ☐ No Describe:
Ongoing TREATMENT:	☐ Yes ☐ No Describe:
Other relevant diagnosis/distressing SYMPTOMS:	
Palliative Performance SCALE (PPS):	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
Anticipated PROGNOSIS:	☐ < 1month ☐ < 3months ☐ < 6months ☐ < 12months ☐ Uncertain Determined by:

RESUSCITATION Status:	Do Not Resuscitate: ☐ Yes ☐ No ☐ Unknown Discussed with: ☐ Individual: ☐ Yes ☐ No Family: ☐ Yes ☐ No

PROVIDERS and SERVICES Involved:			
Who:	Name:	Phone:	Fax:
Family Physician			
Ontario Health at Home			
Community Nursing			
Hospice			
Other			

Family / Informal CAREGIVERS:			
Power of Attorney for Personal CARE:			
Name:	Relationship:	Preferred Phone:	Alternate Phone:

Past Medical HISTORY:			
Diagnosis:	Year:	Diagnosis:	Year:

Allergies (if known): ☐ Yes ☐ No ☐ Unknown
If yes, specify:

INFECTION Control:	☐ MRSA/VRE (+) ☐ C-Diff (+) ☐ ESBL ☐ Other, specify:
Symptom Management Kit in the HOME:	☐ yes ☐ no ☐ not known
Additional INFORMATION: (details of social situation, equipment needs, needs/concerns of the family)	

MEDICATION:	□ Medication list attached □ other attached:
Referring ORGANZATION:	
INDIVIDUAL completing the form:	Name: Phone: Fax:
REFERRING Physician:	Name: Preferred Phone Number: Fax:

IMPORTANT:
Please ensure you have provided
your cell phone or backline phone number
so our intake team and MD can speak to you directly.

For further information about our referral process, eligibility criteria or general inquiries, please contact us at 905.838.3534 ext. 2252.

HILLS of HEADWATERS COLLABORATIVE
ONTARIO HEALTH TEAM

Updated 01272026