



Nancy Chan Palliative Care Ambulatory Clinic

Referral Form: Cardiac Palliative Care

580 – 999 West Broadway
Vancouver, BC V5Z 1K5

Tel: 604-659-1160 Fax: 604-738-4031

Referral Date: ____/____/____
 PHN _____ MRN _____
 Clients GP/NP _____
 GP/NP Ph: _____ Fx: _____
 PARIS #: _____

CLIENT DETAILS

Name: _____ Gender: M / F / Trans DOB: (dd/mm/yyyy): _____
 Permanent Address: _____ City: _____ Postal Code: _____
 Primary Tel: _____ Can we leave a message? Yes No Email: _____
 Primary Contact (Name): _____ Tel: _____ Alt Tel: _____
 Language: _____ Does Client/Family need a translator booking for the clinic appt? Yes No

INSTRUCTIONS

1. Complete requests are expedited 2. **Fax to 604-738-4031** 3. We will contact patient directly

REASON FOR REFERRAL

<input type="checkbox"/> Advanced care plan	<input type="checkbox"/> Caregiver stress	<input type="checkbox"/> Goals of care	<input type="checkbox"/> Pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Spiritual concerns	<input type="checkbox"/> Family tension	<input type="checkbox"/> Financial	<input type="checkbox"/> Nausea	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dyspnea
<input type="checkbox"/> Decision making	<input type="checkbox"/> Living at risk	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Other: _____	

URGENCY

1-2 wks 2-4 wks

Prognosis > 1yr < 1yr < 6m Unknown

Is client / family aware of life-limiting diagnosis: Yes No

HEALTH INFORMATION

Primary Diagnosis: _____

Other illnesses affecting health: _____

HEALTHCARE TEAM

VGH Heart Function Clinic (604) 875-5806 fax
 AFib Clinic (604) 875-5806
 Cardiac Rehab Clinic (604) 875-5794
 Cardio Oncology Clinic (604) 875-5806
 Aortic Clinic (604)875-5806

Cardiologist office _____
 Fx: _____

Other Specialist _____
 Fx: _____

If known

Community RN: _____
 Community site: _____
 Ph: _____

OFFICE USE ONLY:

Appointment Date: _____ Time: _____ Client seen within urgency date: Y N

Appt. cancelled due to: Too ill to attend/ Home visit booked Goals of Care do not meet Clinic Criteria

Hospitalization Client declined Other: _____

Actions:

Telephone follow-up Returning for follow-up Referred to Community Services Admitted to PCU Discharged referral