VON ALGOMA

Volunteer Hospice Service Referral Form

Referred by: ________________________________ Phone/ext: ________________

Organization: ______________________ Date of Referral: ____________________

CLIENT NAME: ____

Address________________________________ Telephone _____________

Date of Birth ____________________________ Sex: ☐ M ☐ F

Living Situation: ☐ Alone ☐ Family: __________________ ☐ Other: _________

Primary Caregiver: _________________________ day phone: _______________
Cell:_______________

Other family/caregivers involved: ____

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Palliative Care Doctor: ___________________ Primary Care Doctor: ____________

Diagnosis: ____

Client Aware of Diagnosis? ☐ Yes ☐ No **DNRC**: ☐ Yes ☐ No **PPS:** __________

Current/planned treatment: ____

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Comments: ____

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Admission Criteria:

A. Individual with a terminal illness seeking palliative support, or

B. Caregiver of a terminally ill loved one seeking support, or

C. Family requiring bereavement support

Revised 2014

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