Northeastern Ontario
Palliative Pain & Symptom Consultation Services
REFERRAL FORM

Member of the PCCNetwork of Ontario, serving the areas of Algoma, Sudbury Manitoulin, Parry Sound, Nipissing, Cochrane, Temiskaming and Muskoka Districts

Person Requesting Referral ______________________________ **Telephone Number:** ______________

Client Name ____ **Age:** ______

Client Location: Hospital _____ **Home** _____ **Long-term Care Facility** ______ **room #:** ______

Home Address (if required): ____________________________________ **Postal Code:** _____________

Telephone: ________________ **Language Preferred: English** □ **French** □ **Other:** ______________

Diagnosis: ____

Medical Conditions and/or Limitations: ____

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Pain Intensity or Symptom Intensity: ____

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Symptom / Side Effects: ____

Medications: please attach copy of medication list with referral

PPS Score _________________ **ESAS pain score** ____________________

Attending Physician: ______________________________ **Phone Number**________________________

Client / Family Agree with Referral? **No** ____ **YES** _____

Reason for referral: P&S Management______ **Education** _____ **Consultation** ______ **Resource material** ______

Other: ____

Referred by: _________________________ **Agency:** _______________ **Date:** ____________________

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Office Use Only

Consultant: Date:

Services Provided: Education □ Consultation □ Resource material □ Other □

Total Consultation Hours:

Administered by VON Algoma