

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: _____

Pain Intensity or Symptom Intensity: _____

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 <input type="checkbox"/> Consultation <input type="checkbox"/> Resource material <input type="checkbox"/> Other <input type="checkbox"/>	
Total Consultation Hours: _____	

Administered by VON Algoma

