Referral to The Bridge Hospice

Phone: 705-924-9222 ◆ Fax: 705-924-9916

Urgency of Admission Request: ☐ 1 -2 days ☐ 1 – 2 weeks ☐ Future

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

OHC: _____ **Version Code:** _____ **Gender:** _____

SDM/POA: _____ **Phone:** _____

MRP: _____ **Phone:** _____

Current Location: ☐ Home ☐ Hospital ☐ LTCH ☐ Retirement Home ☐ Other: _____

PPS: ☐ **10%** ☐ **20%** ☐ **30%** ☐ **40%** ☐ **50%** **Status:** ☐ Stable ☐ Changing

Prognosis: ☐ ≤ 1 mos ☐ ≤ 3 mos ☐ 3 - 6 mos ☐ > 6 mos **DNR:** ☐ Yes ☐ No ☐ Unknown

Primary Palliative Diagnosis: _____ **Diagnosis Date:** _____

Metastatic Spread? ☐ No ☐ Yes (details): _____

Comorbidities: _____

Care Needs: ☐ **CADD Pump** ☐ **SC meds** ☐ **Oral Meds** ☐ **Therapeutic Surface** ☐ **Oxygen @ _____LMP**
☐ **Wound Care:** _____ ☐ **Foley size** _____
☐ **Other:** _____

Allergies: _____ **IPAC:** ☐ MRSA ☐ VRE ☐ C.DIFF ☐ _____

MAiD: ☐ **Not Applicable** ☐ **Under consideration** ☐ **Application in progress** ☐ **Assessments complete**

Psychosocial Support: ☐ Patient Needs ☐ Family Needs ☐ In place (details):_____

Additional Details:

Referred by: _____ **Contact #:** _____

Referral Source: ☐ **Family MD/NP** ☐ **Hospital** ☐ **Palliative MD/NP** ☐ **LHIN – HCC** ☐ **PCCT**
☐ **Other:** _____

PLEASE ATTACH: ☐ **Current Med Orders** ☐ **Relevant LABs, Consults, Pathology, etc.** ☐ **Copy of DNR**