Referral Form – Annapolis Valley Palliative Care Program

Patient Information (addressograph label may be placed here)	
Name: ☐ M ☐ F	**DOB:**
Address:	**Patient Unit Number:** ☐VRH_____ ☐SMH_____ ☐ACHC_____
NS Health Card Number:	**Patient Phone Number:**
Contact Person:	**Contact's Phone Number:**
Health Information	
CPR: ☐ Yes ☐ No ☐ Unknown	**Family Physician:**
Referral Date:	**Referred by:**
Diagnosis:	**Specialist(s) Involved:**
Notes & Reason for Referral:	

Referral Information*

Referrals by FAX (# in brackets):

☐ AVH Palliative Care Team (542-6607)
☐ Cancer Navigator (690-2801)

Referrals to Following:**

☐ Continuing Care NS Phone: 1-800-225-7225 (7days/week)
FAX: 1-866-246-4554 (Mon-Fri)

Volunteer Services:

☐ VON (690-2106)
☐ Mid-Valley Palliative Care {Middleton area} (825-0599)

*** NB: Please fax this form to ALL services being requested**
****If Continuing Care referral – call 1-800 number or FAX this form + Continuing Care Referral Form**

Recent Investigations: **(please attach)** ☐ Specialist Consult ☐ X-Ray ☐ Lab ☐ Other	**Urgency of Consult:** ☐ Within one week ☐ Crisis ☐ Routine (> one week)
Is the patient aware of his/ her condition? ☐ Yes ☐ No **Aware of referral?** ☐ Yes ☐ No	**Patient's Current Location:** ☐ VRH ☐ Home ☐ SMH ☐ QEII ☐ ACHC ☐ Other_____