

Palliative Primary Health Care and Outreach Services

Client Information:

Client's First Name

Last Name

Client's Preferred Name

Gender

Language(s) Spoken

Phone Number: _____ *(permission to leave message ☐)*

_____-_____-_____
Health Card Number

Date of Birth: ____/____/____
DD MM YYYY

Address

City

Postal Code

Allergies

Does this client have a Primary Care Provider?

(Primary Care Nurse Practitioner or Family Doctor)

☐ Yes

☐ No

Reasons for Referral: _____

Housing Situation: _____

Reason Client is Unable to Access Mainstream Health Care Services: _____

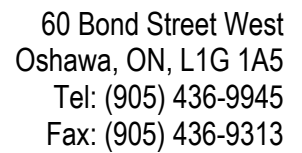
Does this Client Require Palliative Primary Care?

Primary Palliative Diagnosis:

☐ Yes ☐ No

Date of Diagnosis if known (mm/yy):

Mental Health Diagnosis:



☐ Hx Violence towards others	☐ Sexual aggression	☐ Hx Concealing weapons
☐ Hx Violence towards self	☐ Hx Suicide Attempt	☐ Hx Fire-setting
☐ Hx Violence towards property	☐ Pets	☐ Smoking in the home
☐ Roommate/ Family concerns	☐ Falls (if yes, describe functional mobility/assistive devices):	

☐ Substance Use (type, amount, frequency)

☐ Any other risks: _____

Legal Status: (if no legal involvement, leave this section blank)

☐ Criminal record ☐ NCR ☐ Current charges (if yes, please describe):

☐ I'm referring myself	☐ I'm referring a client with their consent:	
Referrer's Name (if not the client)	Phone Number	
Relationship to Patient	Date of Referral: / / DD MM YYYY	