MAISON DE SOINS PALLIATIFS
PALLIATIVE CARE RESIDENCE
VAUDREUIL-SOULANGES

REQUEST FOR ADMISSION TO THE VAUDREUIL-SOULANGES PALLIATIVE CARE RESIDENCE

PATIENT PROFILE

Surname : _____ Given Name : _____ Age : _____

RAMQ : _____ Birth Date : _____ Marital Status : _____

Address: No _____ Street _____ Municipality : _____ Tel. : _____

Language spoken at home: ❑ French ❑ English ❑ other _____
Patient is currently: ❑ at home ❑ in hospital ❑ other _____
Is the patient currently receiving homecare services? ❑ no ❑ yes - specify _____

Request for Admission : ❑ urgent ❑ non-urgent

Reason for Application : ❑ end of life care ❑ symptom control

Expectations : ❑ to stay home as long as possible ❑ to die at home ❑ to die in a healthcare institution

Previous advance wishes **:** ❑ Level of care and CPR form ❑ Advance medical directive

Comments **:** _____

FAMILY AND SOCIAL NETWORK PROFILE

Contact Person : Name _____ Relationship _____ Tel. : _____

Main Caregiver : Name _____ Relationship : _____ Tel. : _____

Mandatary : Name _____ Relationship : _____ Tel. : _____

Homologated mandate : ❑ yes ❑ no The patient is competent : ❑ yes ❑ no

❑ The family network has expressed their inability to deal emotionally with the death of their loved one at home
❑ The family network is not very available ❑ The main caregiver is exhausted
❑ The family has identified significant behavioural changes (agitation, aggressivity, confusion, other) :_____

The patient is aware of the : ❑ diagnosis ❑ prognosis ❑ the patient is aware of this admission request
Patient's family is aware of the : ❑ diagnosis ❑ prognosis ❑ the family is aware of this admission request
Comments **:** _____

REFERRING INSTITUTION

Institution :_____ Unit : _____
Tel. : _____#_____ Fax : _____

Case manager : _____ Profession: _____
Pager : _____ Tel. : _____# _____ Fax : _____
Signature _____ Date : _____

Physician : _____ Institution / Clinic : _____
Pager : _____ Tel. : _____# _____ Fax : _____
Signature _____ Date : _____

Please attach

- ✓ **The medication lists / Pharmacological profile**
- ✓ **The signed consent form**
- ✓ **Level of care and cardiopulmonary resuscitation, AMD form**
- ✓ Summary of most recent hospitalization
- ✓ Pertinent consultation notes or reports
- ✓ Recent laboratory and histopathology reports
- ✓ Recent medical imagery reports
- ✓ Multiclientele assessment tool (OEMC)

MAISON DE SOINS PALLIATIFS
PALLIATIVE CARE RESIDENCE
VAUDREUIL-SOULANGES

Patient : Surname _____

Given Name _____

MEDICAL PROFILE

Primary diagnosis : _____ Date of diagnosis _____

Metastases : ❑ no ❑ yes (site / date): _____

Palliative performance scale rating : PPSv2 **:** _____ % or other (ECOG, Karnofsky) : _____

Prognosis : ❑ **< 2 weeks** ❑ **< 6 weeks** ❑ < **3 months** ❑ **> 3 months**

estimated by : date :

Treatments received :

Surgery : ❑ no ❑ yes - type / date : _____

Chemotherapy : ❑ no ❑ yes - date of the last treatment _____

Radiotherapy : ❑ no ❑ yes - site / date _____

Complications :

❑ Ascites ❑ Edema ❑ Lymphedema ❑ Pleural effusion ❑ Bowel obstruction
❑ Cachexia ❑ Delirium ❑ Seizures ❑ Spinal cord compression ❑ Psychological distress
❑ Wounds / ulcers _____ ❑ Fractures _____ ❑ Hemorrhage
❑ Autres : _____

Symptoms :

❑ Pain (type / location) _____ controlled : ❑ yes ❑ no
❑ Dyspnea ❑ Cough ❑ Fatigue ❑ Weakness ❑ Drowsiness ❑ Insomnia
❑ Anxiety ❑ Agitation ❑ Aggressivity ❑ Confusion ❑ Urinary incontinence ❑ Fecal incontinence
❑ ↓ Appetite ❑ ↓ Weight ❑ Dysphagia ❑ Nausea ❑ Vomiting ❑ Constipation
❑ Other _____

Ambulation : Mobilizes: ❑ Alone ❑ With assistance ❑ Mainly sit/lie ❑ Mainly in bed ❑ Totally bed-bound
Fall risk: ❑ yes ❑ no

Intake : ❑ Normal ❑ Reduced ❑ Minimal to sips ❑ Mouth care only

Self care : ❑ Full ❑ Assistance required ❑ Total care

Conscious level : ❑ Full ❑ Drowsy ❑ Coma

Specific care required, specific equipment and measures :

❑ Urinary catheter ❑ Nephrostomy ❑ Tracheostomy ❑ Oxygen therapy _____ L/min
❑ Colostomy ❑ Gastrostomy ❑ Pacemaker / Defibrillator ❑ Central venous catheter : _____
❑ Wound care ❑ Drain :_____ ❑ Surveillance _____
Other _____

Presence of infection : ❑ MRSA ❑ VRE ❑ C-Difficile ❑ Other : _____

Other diagnosis : _____ **Known cognitive impairment :** ❑ yes ❑ no

Allergies / Intolerances : _____

Comments **:** _____

Transmit by fax or e-mail