NEAR NORTH PALLIATIVE CARE NETWORK
347 Sherbrooke Street, Suite 302, North Bay, Ontario, P1B 2C1
Phone: (705) 497-9239 1-800-287-9441 Fax: (705) 497-1039
E-mail: nnpcn@nnpcn.com Website: www.nnpcn.com

REFERRAL FORM PALLIATIVE CARE CLIENT

Please remember that this is not an emergency service.
Referrals will be handled as expediently as possible.

Referral Date: _____ ***Client #***_____
Month/Day/Year

Last Name:		**First Name:**	
Address:		**Province**	**Postal Code**
Phone Number (Home)	**Gender:**	**Date of Birth:** _____ _____ **Month/Day/Year**	**Language Preference:** **English ☐ French ☐**
Diagnosis:	**Attending Physician**		**Hospital Discharge Date** _____ **Mon/Day/Year**
Does Client Agree with Referral? **Yes ☐ No ☐**	**Living Will Discussed:** **Yes ☐ No ☐**		**DNR Discussed:** **Yes ☐ No ☐**

REFERRED BY:

Physician/LTC/Family Information:		**Phone Number**
Agency	**Agency Contact Person**	**Phone Number**
Febrile Respiratory Illness Screening Completed **Yes ☐ No ☐**	**Date Completed**_____ **Copy Attached Yes ☐ No ☐ ☐**	
Significant Other	**Relationship**	**Phone Number**
Family Member:	**Relationship**	**Phone Number:**

PRIMARY CARE-GIVER CONTACT INFO:

Name:	**Relationship**	**Phone Number:**
Address	**City**	**Postal Code**

SUPPORT IN PLACE AT PRESENT:

Nursing:	**Home-Making:**
Other support:	