WIND RIVER HOSPICE HOUSE REFERRAL

This Hospice Referral must be completed along with the Continuing Care Facility Referral form.
Fax completed forms to 867-456-6744.

Patient last name	Patient first name	Date of birth YYYY/MM/DD

To be completed by hospice palliative care applicants

Physician information

Referring physician	Family physician

Attending physician for placement (if known or different from above)

Is a palliative care physician* involved?

If yes: Name of palliative care physician: _____

*Note: A palliative care physician is involved in the hospice intake process.

Diagnosis

Palliative performance scale score

☐ 10% ☐ 20% ☐ 30% ☐ 40-50% ☐ 60-100%

Date of diagnosis
YYYY/MM/DD

Primary palliative diagnosis (if not already provided on the Continuing Care Referral form)

Other relevant diagnosis/symptoms

Prognosis

☐ < 1 month ☐ < 3 months ☐ 3-6 months ☐ Greater than 6 months

Additional information

Spiritual/cultural considerations

End of life considerations

Awareness of	Individual	Family
Palliative diagnosis	☐ Yes ☐ No ☐ Does not wish to know	☐ Yes ☐ No ☐ Does not wish to know
Palliative prognosis	☐ Yes ☐ No ☐ Does not wish to know	☐ Yes ☐ No ☐ Does not wish to know

The personal information contained in this form is collected, used and disclosed in accordance with the *Health Information Privacy and Management Act* and other applicable legislation. Health and Social Services' information practices may be viewed at www.hss.gov.yk.ca/healthprivacy.php.

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CONTINUING CARE FACILITY OR COMMUNITY DAY PROGRAM REFERRAL

(FORMERLY CCTRF)

Form compiled by: _____

Date completed: YYYY/MM/DD _____

Continuing Care fax: 867-456-6744

For: ☐ Permanent placement ☐ Respite
☐ Community day program (CDP) ☐ Reablement
☐ Hospice ☐ Hospice respite

Surname	Given name		Date of birth YYYY/MM/DD
Address		City	Postal code
Email	Phone	First Nation no.	Veteran
Physician	Clinic		
YHCIP no.	Pharmacy		
Flu shot ☐ Yes. Date: YYYY/MM/DD ☐ No	COVID-19 vaccine ☐ Yes. 1st dose: YYYY/MM/DD 2nd dose: YYYY/MM/DD ☐ No		TB clearance date (mandatory) YYYY/MM/DD
Home care coordinator		Phone	
Services receiving		Frequency	
Other agencies/programs/treatments involved			
Medical history/diagnosis		Code status ☐ Full code ☐ No code (do not resuscitate) ☐ Unknown ☐ Undecided	
		Advanced directive ☐ Yes ☐ No	
		Psychiatric history ☐ Yes ☐ No	
		Drug allergies	

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Diet type
☐ Gluten free ☐ No added sugar ☐ Tube feed ☐ Low lactose

Food texture
☐ Regular ☐ Mechanical soft ☐ Cut up ☐ Minced ☐ Puree

Fluid consistency
☐ Regular ☐ Nectar thick ☐ Honey thick

Special needs or concerns

Food allergies

Food intolerances

Psychosocial status
☐ No concerns ☐ Agitation ☐ Aggression ☐ Anxiety ☐ Suspiciousness
☐ Other: _____

Height	Weight

Communication impairments
☐ Cognitive-communication disorder ☐ Dysarthria
☐ Voice disorder ☐ Aphasia

Dentures
☐ None ☐ Full ☐ Partial

Vision	Uses glasses	Ability to communicate wants/needs/symptoms
☐ Good ☐ Fair ☐ Poor ☐ Legally blind	☐ Yes ☐ No	

Hearing	Hearing aids	Language(s) spoken
☐ Good ☐ Fair ☐ Poor ☐ Deaf	☐ Left ☐ Right	

Mobility devices
☐ Wheelchair ☐ Walker ☐ Prosthesis ☐ Cane

Smoker
☐ Yes ☐ No

Additional equipment used at home (e.g. ostomy, home oxygen, communication devices)

Contact person		Relationship
Address		Email
Home phone	Work phone	Cell phone

Alternate contact		Relationship
Home phone	Work phone	Cell phone

Name

Mobility	**Transferring**
☐ Independent	☐ Independent
☐ Minimal assistance (stand by)	☐ Minimal assistance (stand by)
☐ Moderate assistance (1 person assistance)	☐ Moderate assistance (1 person assistance)
☐ Full assistance (2 person assistance)	☐ Full assistance (2 person assistance / mechanical lift)
Eating	**Toileting**
☐ Independent	☐ Independent
☐ Minimal assistance (tray set up)	☐ Minimal assistance (washroom cueing)
☐ Moderate assistance (feeds self – 50%)	☐ Moderate assistance (assist in washroom – 1 person)
☐ Full assistance or tube feed	☐ Full assistance (2 person assistance)
Special needs	**Elimination**
☐ R.N. treatment	☐ Continent
☐ Footcare	☐ Incontinent – urinary (self managed)
☐ Occupational therapy	☐ Incontinent – urinary (requires assistance)
☐ Physical therapy	☐ Incontinent – bowel (requires assistance)
Social Interaction	**Cognitive status**
☐ Able to interact with individuals and/or in group settings	☐ No concerns
☐ Minimal encouragement needed to participate	☐ Minimal confusion (some STM loss/needs minimal cueing)
☐ Moderate encouragement to interact	☐ Moderate confusion – difficulty following simple directions (needs moderate cueing)
☐ Needs 1-to-1 attention	☐ Maximum confusion (cannot follow directions and difficulty verbalizing needs)
Elopement	**Dressing**
☐ No risk	☐ Independent
☐ Occasional (needs redirection 1-2 times per day)	☐ Minimal assistance (stand by)
☐ Actively attempts to leave (redirection difficult)	☐ Moderate assistance (1 person assistance)
	☐ Full assistance (2 person assistance)
Hygiene (a)	**Hygiene (b)**
Sink tasks (hands, hair, teeth)	**Bathing** (tub, shower)
☐ Independent	☐ Independent
☐ Minimum assistance (stand by)	☐ Minimum assistance (stand by)
☐ Moderate assistance (1 person assistance)	☐ Moderate assistance (1 person assistance)
☐ Full assistance (2 person assistance)	☐ Full assistance (2 person assistance)
Additional medical equipment considerations	
☐ IV meds	☐ Mechanical ventilator, CPAP machine, Bipap
☐ Tracheostomy: additional med supplies (list):	Settings: _____
_____	Hours of use:_____
_____	Independent to turn on and off? ☐ Yes ☐ No
_____	☐ Abdominal pleurex catheter
_____	☐ Thoracic pleurex catheter
☐ Receiving chemo:_____	☐ Defibrillator deactivated ☐ Yes ☐ No
☐ PIC line	☐ Oxygen needs: ☐ Concentrator ☐ Canister
☐ Central line	☐ Rate of oxygen needs:_____

Community Day Program applicants – complete this additional section					
Attendance day(s) requested ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday					
Method of transportation ☐ Family ☐ Taxi ☐ Handi-Bus ☐ Walk ☐ Own vehicle ☐ Don't know					
Reason for referral ☐ Social ☐ Nutrition ☐ Cognitive ☐ Emotional				Referring agency	
Bath requested? ☐ Yes ☐ No	Preferred bath day ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday				
On placement wait list ☐ Yes ☐ No	Pre-admission tour requested ☐ Yes ☐ No				
Current activities and interests					

Fax to Continuing Care admissions office: 867-456-6744

For CDP coordinator use only			
Total score /55	Admission date	Referring agency notified ☐ Yes ☐ No	Client/family notified ☐ Yes ☐ No

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CONTINUING CARE

COMMUNICABLE DISEASE SCREENING FOR WIND RIVER HOSPICE HOUSE ADMISSIONS

When complete, return this form via email or fax it to 867-667-9332 and address to: Wind River Hospice House Manager and Nurse Supervisor

For any questions, contact Wind River Hospice House at 867-667-9367.

Patient last name	Patient first name	YHCIP #
Most responsible provider name	Most responsible provider signature	Date of signature YYYY/MM/DD

_____ is seeking a hospice or respite bed at Wind River Hospice House.
(print name)

This document confirms that a risk assessment for communicable disease (e.g., tuberculosis, HIV, hepatitis, COVID-19, influenza) has occurred, taking into account any relevant signs, symptoms, physical exam, laboratory and imaging findings.

Please check the box which best matches the patient situation:

☐ There are currently no active communicable disease concerns, no pending communicable disease investigations, and no clinical indications for new or repeat testing.

☐ The patient has the following communicable disease concerns and/or pending investigations

_____

_____

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Yukon

ANAPHYLAXIS STANDING ORDERS

Resident/client last name	Resident/client first name
Date of birth	Yukon health care number

☐ **Long-term care resident** – Orders are in place unless alternate orders are provided by physician/nurse practitioner.

☐ **Home Care client** – Physician/nurse practitioner **must sign to approve** orders, or provide alternative orders.

Signature: _____

These medications and guidelines are approved anaphylaxis standing orders for long term care home residents and Home Care clients. The RN or LPN may administer the emergency medications based on clinical judgment, as per Continuing Care's Anaphylaxis Protocol. The physician/nurse practitioner will be informed post-anaphylactic event.

☐ Adult

If signs and/or symptoms of anaphylaxis are present:

- **For adults and children who weigh 30kg or more, give Epinephrine 1:1000 per Epi-Pen subcutaneous (0.5 mg Epi-Pen Auto-Injector).**
- Call 911. Place resident/client in a recumbent position with feet elevated, if possible and tolerated. Q 5-10 minutes, monitor vital signs, airway, level of consciousness and signs/symptoms.
- **Give Epinephrine up to three times at 5 to 15 minute intervals, if necessary** for severe reactions.
- **Give adjunctive one-time dose of Diphenhydramine Hydrochloride 2.5 mg/kg to a maximum of 100 mg po or IM.** For the conscious resident/client who can swallow, the oral route is preferred as IM injections are painful. Oral and IM dosages are the same.
- Transfer to hospital by ambulance.

☐ Child or youth

If signs and/or symptoms of anaphylaxis are present:

- **For children weighing between 15 kg to 30 kg, give Epinephrine per Epi-Pen Jr 1:2000 Auto-Injector, 0.15 mg.**
- **For children less than 15 kg, specific orders will be provided by the physician.**
- Call 911. Position the child in a recumbent position with feet elevated, if possible and tolerated. Q 5-10 minutes, monitor vital signs, airway, level of consciousness and signs/symptoms.
- **Give Epinephrine up to three times at 5 to 15 minute intervals, if necessary** for severe reactions.
- **Give adjunctive one-time dose of Diphenhydramine Hydrochloride 2.5 mg/kg to a maximum of 100 mg po or IM OR use the following dosage chart.** For the conscious child who can swallow, the oral route is preferred, as IM injections are painful. Oral and IM dosages are the same. Children under 12 years will be provided Diphenhydramine elixir for oral doses.

Age	Diphenhydramine (oral or injected dosage)
Under age 2 years	0.25 ml (12.5mg)
Age 2 to 4 years	0.50 ml (25mg)
Age 5 to 11 years	0.50 – 1.00 ml (25-50mg)
12 years or older	1.00 ml (50mg)

- Transfer to hospital by ambulance.