Referral Form

St. Joseph's Health Centre, Palliative Care and Symptom Improvement Clinic
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ST. JOSEPH'S UNITY HEALTH TORONTO

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Patient Information

First Name: Surname:		
Address:		
Date of Birth: (DD/MM/YY)	Age:	Sex: M F Non-Binary
Contact Name & Phone Numbers:		
Health Card Number:		Version Code:

Referring Provider Information

Name:	Address:	
Phone Number:	Fax Number:	Provider Billing #:

Priority: ☐ Urgent (24-48 hrs) For urgent referrals, must call the clinic ☐ Semi-urgent (less than 1 week) ☐ Routine (1-2 weeks)

Diagnosis: _____

Accommodations Required (please list): _____

Reasons for Referral (check all that apply):

☐ Values & goals of care	☐ Fatigue	☐ Pruritus	☐ Improved home supports
☐ Pain	☐ Constipation	☐ Insomnia	☐ Information about MAiD
☐ Shortness of Breath	☐ Appetite	☐ Caregiver challenges	☐ Advanced care planning
☐ Nausea	☐ Distress around illness	☐ Physical Symptoms (please specify)	
☐ Other (please indicate)			

For clinic use only

Additional details for triage:

Process Instructions:

Scheduling Instructions:

Comments: