SOINS À DOMICILE ✦ HOME CARE

Referral | **Palliative care and end-of-life care**

User

Last name:

First name:

Date of birth:

Gender: M ◯ F ◯ Other ◯

Language of communication:

RAMQ number:

Telephone number:

User address:

City: Postal code:

Primary diagnosis and reason for request:

Requested by:

Department:

Establishment:

Telephone number:

Email:

Caregiver

Full name:

Date of birth:

Language:

Relationship with user:

Telephone number:

Other phone number:

Needs according to the caregiver:

Medication:

Pharmacy (name and phone number):

Infectious disease or related diagnosis:

Allergies:

Medical follow-up

Full name:

Specialty:

Telephone number:

Establishment:

Full name:

Specialty:

Telephone number:

Establishment:

Other professionals involved and services

Name:

Profession:

Telephone number:

Name:

Profession:

Telephone number:

Description of services, care, and equipment put in place by the public system:

Issues and functional capacity

☐ Behaviour ☐ Mobility

☐ Cognitive functions ☐ Communication

☐ Identified risks

Specifics:

Situation – family support

Specifics:

Description of the support network:

Other information:

User or authorized person consents to referral and transmission of information

◯ Agree ◯ Disagree

Date:

Name:

Signature: