



The following information must be supplied prior to consideration of any application for admission

Name: _____ Tel. No: _____ Date of Birth: _____	Address: _____ _____ Medicare No.: _____
Referring institution / agency: _____ Name of referring person : _____ Telephone of referring person: _____	Patient is currently: At Home(____) In Hospital(____) Date of admission: _____ Current Physician: _____ Next of Kin: _____

Medical History Primary Disease: _____
Reason for application: _____

I. Diagnosis

- a) Date of original diagnosis: _____
- b) Extent of disease at time of diagnosis: _____
- c) Documented metastases (dates and sites): _____
(Please attach pathology reports)
- d) Other complications: (effusions, ascites, pathological fractures, etc.) _____

II. Treatment

- a) Surgical interventions _____
- b) Chemotherapy (dates and response): _____
- d) Hormonal therapy (dates and response): _____
- b) Radiotherapy (dates and response): _____

III. Symptoms attributable to the primary disease

- a) Pain Yes (____) No (____) Site _____
- b) Incontinence Yes (____) No (____)
- c) Loss of functional capacity Explain _____
- d) Change in mental status (mood, thought processes, Ie: signs of psychosis Cognitive functions: level of consciousness, confusion, delirium) _____
- e) Other distressing symptoms i.e. nausea, dyspnea, etc. (specify): _____

IV. Prognosis

- a) Estimated life expectancy: <2 weeks (____) <6 weeks (____) 6-12 weeks (____) > 3 months (____)
- b) Is Patient candidate for further palliative procedures: _____
i.e. radiotherapy, thoracentesis etc. (please specify)
- Physician's signature: _____ Date: _____



NAME: _____ DATE OF BIRTH: _____

V. Other medical history (Please include active and inactive problems)

VI. Medications:

Allergies / adverse reactions:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VII. Investigations: *Please attach copies of the latest laboratory, x-ray, scan and pathology reports.*

VIII. Patient's experience with the primary disease

- a) Does the patient know his diagnosis? Yes (___) No (___)
- b) When was the patient told of the diagnosis? _____
- c) Does the patient know his prognosis? Yes (___) No (___)
- d) What is the level of understanding of the disease and the prognosis? _____
- e) Why does the pt/family want admission to the residence? _____
- f) What are their expectations? _____
- g) Does the family know the diagnosis? Yes (___) No (___)
- h) Does the family know the prognosis? Yes (___) No (___)

IX. Psychological information

- a) Name & relationship of pt's main caregiver: _____
- b) Has pt had community intervention: CLSC (___) VON (___) Private (___) _____
- c) Does pt expect to die at home or at an institution _____
- d) To what extent has family been involved: _____
- e) Who has informed the patient of the request to be transferred to our residence? _____

X. Additional comments (special needs ie: Spiritual needs or rituals)

Physician's signature: _____ Date: _____