HOSPICE HALIFAX

Hospice Request for Assessment Form

Fax to: (902) 446-0488

Please note that incomplete forms will not be accepted.

Health Card #:	
First Name:	
Last Name:	
DOB (YY/MM/DD):	/ /

OR Affix Label here

Hospice is appropriate for patients who require end of life care. Patients have a life expectancy of less than 3 months and a PPS of 50% or less. The patient/family have care needs that cannot be met at home but do not require the care of an acute care facility. Eligibility criteria can be found at **www.hospicehalifax.ca**

Home Address:

Phone:

Personal Directive: ☐ **Yes** ☐ **No**
Delegate / SDM Name & Relationship:

Phone: _____

Alternate Contact Name & Relationship:

Phone: _____

Primary Care Physician/NP:

Phone: _____ Fax: _____

Palliative Care Home Drug Program: ☐ Yes ☐ No
Is Continuing Care Nova Scotia involved? ☐ Yes ☐ No

Current Location: ☐ Home ☐ Other: _____
☐ Hospital/Unit _____ Unit Phone: _____

Please attach either: A) a signed DNR form *(Link: Department of Health and Wellness DNR Form for Physicians)*

or B) a signed NSHA Goals of Care Form with Level of Intervention: **"Comfort is the primary goal of care."**

Review the attached **Hospice Halifax Admission Agreement** with your patient/their SDM and ***ensure it is signed*** before sending request.

Primary Diagnosis: **Date of Diagnosis:**

Other significant medical conditions
(e.g. seizures, Type I Diabetes):

Is the patient aware of their prognosis? ☐ Yes ☐ No

Is Pt/Delegate/SDM aware of this request? ☐ Yes ☐ No

Have funeral arrangements been discussed? ☐ Yes *Details:*_____ ☐ No

Estimated Prognosis: ☐ days to weeks ☐ weeks to less than 3 months

Functional status: Palliative Performance Score* at referral: _____% **(must be ≤ 50%,** **scoring guidelines on reverse*)*

Is the QEII Palliative Care Consult Service involved in patient's care? *(Not a requirement for sending form.)* ☐ Yes ☐ No

Reason(s) for referral - check all that apply:

☐ Symptom management - please specify symptom(s):

_____

_____

☐ Patient/family psychosocial needs

_____

_____

☐ Home death not desirable/feasible

☐ Other: _____

If clinical situation is urgent, MD/NP-to-MD contact by phone is required (902) 446-0929.

MRSA: ☐ Yes ☐ No **VRE:** ☐ Yes ☐ No
C.Diff: ☐ Yes ☐ No **TB:** ☐ Yes ☐ No
Other:
COVID vaccination dates:
#1 _____ #2_____ Booster _____
COVID test date: _____ ☐ positive ☐ negative
Wounds ☐ Yes ☐ No
Pressure Injuries ☐ Yes, stage: _____ ☐ No
Oxygen ☐ Yes, _____ l/min ☐ No
Cognitive Impairment ☐ Yes ☐ No Wandering ☐ Yes ☐ No
Aggressive behavior ☐ Yes ☐ No Recent falls ☐ Yes ☐ No

Your Name:
Phone:
Email:_____

Referring MD/NP *(if different from person completing form)*:

Request date:_____

Calculating the PPSv2 Score:

VICTORIA HOSPICE

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

HOSPICE HALIFAX

May 2021

Hospice Halifax Admission Agreement

1. I understand that hospice is for patients who are in the last weeks or months of their life and that my physician has talked to me about my illness and what to expect.

2. I understand that hospice focuses on quality of life by providing a home−like setting and professional care for patients and families. I understand that tests and treatments like regular blood tests, x−rays, chemotherapy, intravenous (IV) treatments and blood products are not provided in hospice. I understand that life−prolonging measures, like CPR or emergency transfers for resuscitation, are not provided in hospice.

3. I can expect that my physical, emotional and spiritual well−being will be the hospice care team's priority. The hospice care team may also work with Continuing Care, my family physician, the local palliative care team, and other healthcare professionals as needed.

4. So that the hospice can provide the best care possible, I give permission for my personal health information to be shared within the hospice care team and authorize the hospice to share my health information with other healthcare providers and learners, when needed. If I no longer wish for my personal health information to be shared, I must tell the hospice in writing.

5. I understand that a team of registered nurses, licensed practical nurses, care team assistants, and physicians care for patients 24 hours a day, 7 days a week at the hospice. Other roles on our team include social work, occupational therapy, and spiritual care.

6. I understand that volunteers are an important part of the hospice care team and will regularly help with my non−medical care and support.

7. I understand that hospice care can improve my condition such that I may no longer need ongoing care at the hospice. If the hospice care team determines that I can be discharged safely to home, or transfer to another care setting like a long term care facility, a transfer or discharge plan will be discussed with me or my delegate/substitute decision maker. If I refuse the transfer or discharge, I understand that additional charges may apply in accordance with NSHA or hospice policy

8. I understand that where it is appropriate to meet my health or personal needs, or the needs of other patients, I can be moved to a different part of the hospice or another facility where necessary care could be provided.

9. I understand that medical care benefits covered under the Nova Scotia Health Insurance Program will continue while I am a patient at the hospice.

10. I understand that my medications will be provided by the hospice's partner pharmacy. Although the pharmacy will try to make sure my medications are covered through provincial or private programs, I understand that if this is not possible, I may be responsible for some costs.

11. I will not hold the hospice responsible for any loss of money, valuables, or personal effects that are kept in the hospice. I will not hold the hospice responsible for any injuries resulting from the care provided to me other than by employees or agents of the hospice.

12. I understand that my delegate or substitute decision maker (SDM) will make health and personal care decisions for me if I no longer have capacity to do so.

13. I can decide to change my care plan at any time. However, if I choose to leave the hospice for treatment or medical investigations elsewhere, I understand that my place at the hospice may no longer be held for me.

◉ **Patient:**

Print Name: _____

Signature: _____

Date (YYYY/MON/DD): _____

or

○ **Delegate / Substitute Decision Maker is to sign Admission Agreement if the patient lacks capacity to direct their care:**

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date (YYYY/MON/DD): _____

Healthcare Professional – I have reviewed the form with my patient:

Print Name: _____

Professional Designation: _____

Signature: _____

Date (YYYY/MON/DD): _____