Canuck Place Children's Hospice
1690 Matthews Ave, Vancouver
V6J 2T2

Telephone: 604-731-4847
Fax: 604-742-3490
Toll free #: 1-877-882-2288

Referral Form

Child's Name: ____________________ **DOB:** ____________________ ♂ ♀

Diagnosis: ____________________ **PHN #:** ____________________

Group: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Taxonomy Group: ☐ Cancer ☐ Cardio Pulmonary ☐ CNS Condition ☐ Chromosomal/Single/Multi Organ Syndromes ☐ Biochemical Disease ☐ Immunologic/Infectious ☐ Neuromuscular

Location of Child: ☐ Home ☐ Hospice ☐ Community Hospital ☐ BCCH ☐ NICU ☐ Other ____________________

Home Address: ____________________

Postal Code: ____________ **Email:** ____________________

Parent's / Guardians Names

Mother: ____________________ Phone: ____________________

Father: ____________________ Phone: ____________________

☐ Married ☐ Separated ☐ Divorced ☐ Single Parent ☐ Foster care ☐ Associate Family

Siblings: 1) ____________________ DOB: ____________ ♂ ♀

2) ____________________ DOB: ____________ ♂ ♀

3) ____________________ DOB: ____________ ♂ ♀

☐ Custody papers required
☐ Ministry Involvement
SW: ____________________

Other information (e.g. family dynamics, family history):

____

Family aware of referral: **Family understands palliative concept of care:**

Referral/Consult Information and Request:

☐ Consultation ☐ Respite Care ☐ Transition Care ☐ Symptom Management ☐ End of Life Care

NOTES:

Supports Currently Available (At Home Program, NSS, Home Care, PT/OT)

____

Important contacts for follow-up (GP, HCN, Pediatrician, Social work, Specialist, NSS):

Name:	Relationship	Contact info:
		Phone Fax:
		Phone Fax:
		Phone Fax:
		Phone Fax:
		Phone Fax:
		Phone Fax:

Referral Source: ____ Phone: ___________________________________

EMAIL: ____ Relationship to Child: _____________________________________

Initial Referral Completed by: ____ Date: ________________________________

Intake Meeting Notes and Follow-up

In attendance: ____

____

Date	Heading	Comments

1) Is the condition progressive and life limiting?

2) Has the GP/Pediatrician been contacted? ☐ Family Handbook provided

Supporting Documentation Received:

Referral completed and closed by: ____Date:______________________________