Palliative Care Referral Process

Patient's Life expectancy is <6 mo.

GP/NP completes Palliative Care Benefits registration form (**bit.ly/pallbenefits**) & Home & Community Care (HCC) referral form (**bit.ly/hcc-refer**)

MOA faxes PC Benefits registration to MOH & HCC along with HCC Referral Form

Liason nurse receives/reviews referral form

HCC calls patient at home to book a home visit for initial assessment

GP/NP makes referrals to other health professionals, e.g. SW, Dietician, Community OT/PT

HCC sets up regular contact schedule or informs GP/NP if visits refused

GP/NP manages symptoms based on office visits and information from HCC nurses, and refers to Palliative Care Rounds as needed

HCC RN sends report of Pt. contact & regular status updates to GP or NP

HCC RN triages patient to appropriate HCC services or Hospice

As PPS declines GP/NP generates "Expected Death at Home" form and makes sure MOST form is current

MOA faxes to HCC

HCC receives & places Expected Death at Home & MOST form in home

HCC notifies GP/NP if family no longer able to manage care at home & require facility admission

Admission to Palliative Bed arranged

Kootenay Boundary
Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients