northern health
the northern way of caring

Designated Hospice Palliative Care Beds
WAITLIST REQUEST FORM

DIRECTIONS for USE

Purpose:

To alert the local HPC Team to the need for a designated HPC bed by a palliative care patient who may require:

a. Short Term admission for symptom control or caregiver respite
b. Longer Term admission for End of Life care.

To gather information that enables objective assessment of:

a. Individual patient/family needs
b. Suitability of care location
c. Comparison among patients to determine admission priority

Policies:

1. Request for a designated HPC bed may be submitted on behalf of a patient and/or family by the Family Physician, or any member of the Interdisciplinary Care Team practicing in the area where the patient is currently located.
2. All requests will be reviewed, evaluated for priority, and approved by the Interdisciplinary Admission Team within the community of the Designated HPC Bed Facility.
3. Approval for the designated HPC bed access will be communicated by completion of **ALL** of the following:
   a. Telephone to the person/site submitting the request
   b. Telephone to the patient/family contact
   c. Fax to the Family Physician (if not the person submitting the initial request)

Procedure:

The person/site requesting admission:

1. **Complete Part I** – **Patient Data** (P.1)
   Fill in the necessary information as specified. Leave the APPROVAL section blank.
2. **Complete Part II – Admission Requirements** (P.2 – must be completed) **& Care Needs** (P.2 & 3 – complete sections as applicable).
   Place a check in the box to indicate that the condition is present /or if the care is needed.
   a. Additional information may be added as needed.
   b. Medication list. Please attach MAR/ medication profile, if needed.
3. **Submit the Request**:
   a. Call the Designated HPC Bed Admission Coordinator at the number indicated at the top of the 1st page.
   b. Fax the form to the number provided.

Local Interdisciplinary Admission Team:

1. Review request for the designated HPC Bed, evaluate need and rank priority (1,2,3). Keep on file for comparison with other requests.
2. **Complete Notice of Approval** (bottom of P.1) and **Fax** (p.1) to person/site requesting admission once approved and a **bed is available**.

Designated Hospice Palliative Care Task Group/JL/April 17/07; June 2/08; July16/08; Jan22/09

CONTACT: Designated Hospice Palliative Care Bed Access Coordinator at:

PHONE: 250 - _____ FAX: 250 - _____

Part I & II to be completed by the person/care site requesting admission – PLEASE PRINT

PART I : INITIAL REGISTRATION

Date: _____

Person Requesting Registration: _____ Phone: _____

Patient Name: _____ DOB (M/D/Y) _____

Family Contact Name: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Other Physicians involved in care: _____

Primary Diagnosis: _____ PPS: _____ %

Secondary Diagnosis: _____

(note any other conditions that may become unstable) _____

ALLERGIES: _____

Antibiotic Resistant Organism (ARO) status _____

Current Location of Patient: _____

Health Care Contact Person* (if different from the person requesting waitlist registration):

_____ Phone: _____

*(HC contact person in community is HCN; in hospital is PCC or RN caring for patient)

Hospice Site Preference: _____

Degree of Urgency: ☐ High ☐ Medium ☐ Low **(Part II -PLEASE TURN to NEXT PAGE)**

NOTICE of APPROVAL (To be Completed by the Interdisciplinary Admission Team) **PRIORITY Rating _____**		
REQUIREMENTS	**YES**	**COMMENTS**
Medical History/ Assessment: • Received from attending MD or HPC MD (request faxed info from MOA - attach copy)	☐	
Plans for patient medical care in Designated HPC Bed: • Family physician will follow patient in hospice • Arrangements made for Alternate MD to provide care Name: _____ Ph: _____	☐ ☐	
Reason for Admission: ☐ End of Life Care ☐ Symptom Management ☐ Planned Respite ☐Other:		
Approval to Waitlist: • Given by HPC Interdisciplinary Team Name: _____	☐	Date: _____
Approved Request Telephone Notification to: • Person requesting Designated HPC Bed • Family Contact Person	☐ ☐	Date: _____ Date: _____
Approved Request Faxed to: • Family MD (if initiated by other)#: _____ • Local Home Care Nursing #: _____ • Hospital #: _____	☐ ☐ ☐	Date: _____

PART II: PRE-ADMISSION ASSESSMENT

Part II to be completed by the person/care site making the request – PLEASE PRINT

ADMISSION REQUIREMENTS	YES	COMMENTS
Patient Registered on BOTH: • NH HPC Program • BC Palliative Care Drug Benefits: Plan P	☐ ☐	
Type of Admission: • End of Life Care; expected prognosis < 3 months • Short Term Symptom Management; prognosis < 6 months • Short Term Caregiver Respite; prognosis < 6 months	☐ ☐ ☐	Dates of Respite Requested:
Anticipate that patient cannot be supported in community	☐	
Discussion of Advance Care Planning: • Has taken place with the patient and family. • No CPR order: ☐ Not at this time ☐ Completed • Advance Care Plan: ☐ Not at this time ☐ Completed	☐ ☐ ☐	
At time of admission patient will <u>not require:</u> • Diagnostic tests • Complex Treatments (chemotherapy, hyperalimentation,etc)	☐ ☐	The patient will not be able to be admitted if either of these are required.
Patient/family aware • On wait listing & in agreement	☐	

Patient/Family CARE NEEDS

Assessment Information	Factors to Consider	Additional Comments
Physical • **Basic Care** ☐ Self care ☐ Assisted ☐ Full care	• **Special Needs** ☐ Caregiver respite ☐ No caregiver ☐ Needs exceed available Home Supports	
• **Symptom Management** ☐ Pain ☐ Sore Mouth ☐ Anorexia ☐ Cachexia ☐ Nausea ☐ Vomiting ☐ Dysphagia ☐ Dyspnea ☐ Constipation ☐ Diarrhea ☐ Anxiety ☐ Agitation ☐ Dementia ☐ Delirium ☐ Fatigue ☐ Depression ☐ Edema ☐ Wounds ☐ Incontinent ☐ Sleep Disturbance ☐ Other: _____	• **Special Needs** ☐ Oxygen/flow rate _____ ☐ Gastric suction ☐ Trach suction ☐ IV ☐ PICC line ☐ VAD Flush _____ ☐ SC pump - model # _____ ☐ Hypodermoclysis _____ ☐ TPN/Tube Feeding ☐ Contact Precautions _____ ☐ Special Supplies ☐ Wound care products ☐ Other: _____	**Medications (dose/ freq)** (attach separate page with MAR or medication profile if needed)
• **Mobility** ☐ Independent ☐ Supervision ☐ Assist (1p) ☐ Lift ☐ Bed Bound ☐ Turning Assist	• **Special Equipment** ☐ Bed/Mattress ☐ Lift _____ ☐ Other: _____	

Assessment Information	Factors to Consider	Additional Comments
Psychological ☐ Interpersonal ☐ Adjustment Issues ☐ Substance Misuse	• **Special Needs** ☐ Counseling _____ _____	
Social ☐ Caregiver Issues ☐ Family/Friend Issues ☐ Financial Concerns ☐ Other _____	• **Special Needs** _____ _____ _____	
Support Network ☐ Family/ Friends ☐ Volunteer ☐ Other Community Agencies	_____ _____ _____	
Cultural ☐ Specific customs/traditions non-religious) ☐ Language & Translation	• **Special Needs** _____ _____ _____	
Spiritual ☐ Faith Community ☐ Spiritual Support Persons Name: _____ Tel#: _____ ☐ Other?	• **Special Needs** _____ _____ _____	
End of Life Planning ☐ Wills/ Representation ☐ Advance Directives ☐ Funeral Plans		

Designated Hospice Palliative Care Bed Task Group/ JL/April 16/07; June 02/08 ; January 14/09