

# Dr Bob Kemp Hospice



## REFERRAL FORM

Fax to 905-387-7822

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone no.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ First Language: \_\_\_\_\_

Previous Pharmacy: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Referral is: Urgent  Days to weeks

Weeks to Months  Stable

Reason for the referral:

Has the patient been informed of this referral: \_\_\_\_\_

Most Recent PPS (if available): \_\_\_\_\_

Most Recent ESAS: Attached  Not Completed

DNR Signed: YES  NO

Other Services patient has at home: \_\_\_\_\_

Dr. Bob Kemp Hospice  
277 Stone Church Rd  
Hamilton, Ontario L9B 1B1  
Phone: 905-387-2448 Fax: 905-387-7822

Next of Kin: Name: Address:	Next of Kin: Name: Address:
Telephone: Home: Business: Other:	Telephone: Home: Business: Other:

**Power of Attorney:**

For Personal Care: \_\_\_\_\_  
Name & Phone Number

**Advanced Directive Completed:** Yes  No

Referral Made By:
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Referral received by: \_\_\_\_\_ Date: \_\_\_\_\_