northern health
the northern way of caring

All Sites and Facilities

Palliative Care Program Registration Form

Patient's name: _____

Address: _____

_____ Postal code: _____

Phone number: _____

DOB: _____ PHN: _____

(or addressograph or stamp)

Fax to Regional Palliative Care Consultation Team 250-565-5596

Family physician: _____ Phone number: _____

Other prescriber(s): _____ Phone number: _____

(Please print clearly)

Diagnosis (primary): _____

_____

Diagnosis (secondary): _____

_____

PPS % _____
(Palliative performance scale)
Version 2 (PPSv2) to determine the PPS level

☐ Rapid decline
☐ Slow decline
☐ Unknown

Allergies:

In order to identify individuals that require palliative care services, a prescriber must **confirm** the palliative care status of the person.

The above individual is:

1. Living with a life limiting progressive illness with a life expectancy of less than 6 months.
2. The individual/designated decision maker is aware and has agreed to accept palliative care.

Are you the attending prescriber who will provide palliative care up to and including death? ☐ Yes ☐ No

If no, please identify the most responsible prescriber for this individual's case (print clearly): _____

Prescriber's signature: _____ Date: _____

I have initiated these services. (Checking these boxes does not initiate services; it is for registry information only.)

☐ BC Palliative Care Benefits form has been completed and submitted

☐ "No CPR" form has been completed

☐ Hospice palliative volunteer services requested by patient/family

☐ Home nursing care referral has been initiated using HCC Referral Form

If you are requiring a formal palliative care consultation please fill out the consultation request form and fax it to the number above.