SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Palliative Consultation Request

Please Fax to ADCP New Referrals clerk: 705-541-7803

Phone 705-541-7807 or On-Call Palliative MD to Review

Referring MD and signature: _____ Date_____

Diagnoses: _____

Reason for referral (Check all that apply):

- ☐ Symptom Control
- ☐ End of Life planning
- ☐ Early Referral
- ☐ Other: _____

Requested Priority:

- ☐ URGENT - Must be MD to MD
- ☐ P1: Within two weeks

****Reason: _____

- ☐ P2: 2 – 8 weeks

Requested Palliative MD:

- ☐ First Available
- ☐ Dr. Buehner
- ☐ Dr. Wilson
- ☐ Rita Mannarino NP
- ☐ Dr. Booth
- ☐ Dr. Apostle

This patient's Primary Practitioner is: _____

Patient's Current Functional Status:

☐ PPS_____% (Refer to Palliative Performance Scale on next page for scoring guidelines)

☐ Other (explain):_____

Non-MD Services already involved (check all that apply):

- ☐ Collaborative Care Algoma_____
- ☐ Home and Community Services (list all services)_____
- ☐ Other: _____

☐ ***I have explained the reason for this Palliative Referral to the patient/POA and the patient wishes to attend the appointment.*** ***Signature of RN:*** _____

For Palliative Programme use ONLY:

Date referral received: _____
Date referral triaged by MD: _____
Date appointment made and patient notified: _____
Date of initial palliative consultation: _____

Would I be surprised if my patient died in the next year??

Information Palliative Consultation Indicators

General Indicators of Approaching End Of Life:

- Decreasing activity – functional performance status declining, limited self-care, in bed or chair 50% of day, increasing dependence in most activities of daily living
- Co-morbidity is the biggest predictive indicator of mortality and morbidity
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further active treatment
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions to hospital
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <25g/l

Disease-Specific Indicators of Decline

Cancer

Metastatic cancer
Performance status deteriorating due to metastatic cancer (PPS ≤ 50%: indicates life expectancy in order of only a few months)
Significant weight loss

Renal Disease

Stage 4 or 5 Chronic Kidney Disease (CKD) whose condition is deteriorating with at least 2 of the indicators below:
Patients choosing the 'no dialysis' option, Discontinuing dialysis
Patients with difficult physical symptoms or psychological symptoms despite optimal tolerated renal replacement therapy
Symptomatic Renal Failure – N&V, anorexia, pruritus, intractable fluid overload

Heart Disease (≥ 2 of the following)

NYHA Class III/IV - dyspnea at rest on minimal exertion
Repeated hospital admission with heart failure
Persistent severe symptoms despite optimal tolerated therapy
Significant weight loss due to cachexia

Dementia

Unable to walk without assistance,
Unable to communicate meaningfully,
Unable to do Activities of Daily Living (ADL), Urinary and fecal incontinence
Plus any of the following: Weight loss, Pressures sores, Recurrent fever (UTI, aspiration pneumonia)

Neurological Disease

Progressive deterioration in physical and/ or cognitive function despite optimal therapy;
Symptoms which are complex and too difficult to control;
Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, dyspnea or respiratory failure;
Increasing difficulty in communication; progressive dysphasia

Information Palliative Consultation Indicators

Respiratory Disease (≥ 2 of the following)
Severe airway obstruction (FEV1<30%)
or restrictive deficit (<60%)
Meets criteria for long-term oxygen therapy
Breathless at rest or on minimal exertion between exacerbations
Persistent severe symptoms despite optimal tolerated therapy
Symptomatic right heart failure
Loss of appetite and weight
Recurrent hospital admissions (≥ 3 in last 12 months)

Liver Disease
Advanced cirrhosis with one or more of:
Intractable ascites, Hepatic encephalopathy, Hepato-renal syndrome, Bacterial peritonitis, Recurrent variceal bleeds
Serum albumin <25 g/l and INR >2
Hepatocellular carcinoma
Not fit for liver transplant

VICTORIA HOSPICE

Palliative Performance Scale (PPSv2)
Version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
PPS 100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
PPS 90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
PPS 80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
PPS 70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
PPS 60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
PPS 50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
PPS 40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
PPS 30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
PPS 20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
PPS 10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
PPS 0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'
3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Maybe my patient can benefit from Palliative Care NOW!