Referral Form
Continuing Care

path clinic
PALLIATIVE AND THERAPEUTIC HARMONIZATION

Understand • Communicate • Plan • Empower

Target population: The PATH outpatient clinic at the Geriatric Ambulatory Care Clinic in the Veterans' Memorial Building is open to clients and their caregivers who:

- have advanced or progressive illnesses;
- have had multiple hospital admissions or uncontrolled symptoms;
- have experienced a progressive decline in mobility, function, or cognition;
- have a dedicated caregiver/family member; and/or
- are interested in receiving more information about their anticipated future health and options for integrating a palliative approach into their existing therapies.

The PATH process involves **3 clinic visits** with the following goals:

Visit 1: Comprehensive assessment of physical, psychological, and social health
Visit 2: Exchange of expectations and information between client, caregiver and health professional
Visit 3: Learning new skills to help with future health decisions

The PATH process is designed to result in improved understanding of prognosis related to health and client/caregiver empowerment to reconcile future health decisions with the client's overall goals.

The PATH may not be for everyone. Clients or caregivers who do not wish to receive information about current and future health, or who do not wish to contemplate future health care decisions should not be referred to PATH.

Referral Information*

Client Name:	Tel:	Referral Date:
Street Address:	City & Province:	Postal Code:
Health Card Number:	Exp:	DOB:
Primary Caregiver:	Relationship:	Tel:
Second Caregiver: (if applicable)	Relationship:	Tel:
Primary Care Physician: Has physician been notified of referral? Check one: ☐ YES ☐ NO	Tel:	Fax:
Referring Care Co-ordinator:	Tel:	Fax:
Chronic Health Conditions:		

Please attach any additional information you feel would be helpful to the PATH team.

FAX TO 902-473-7133

Client Consent: The principles of the PATH clinic have been explained to me. I understand that the PATH requires up to 3 clinic visits. I agree to take part in this process.

Signature: _____ Date: _____

***Referrals received without the client's (or caregiver's, where applicable) signature will not be accepted**