# Referral Form

path clinic
PALLIATIVE AND THERAPEUTIC HARMONIZATION
Understand • Communicate • Plan • Respond

**Target population**: The PATH process aims to improve the patient/family understanding of health status, and empowers the decision maker to consider the impact of frailty when making health decisions

Check all that apply. The patient (family) has:

- ☐ advanced or progressive illness
- ☐ multiple hospital admissions
- ☐ uncontrolled symptoms
- ☐ identified an identified need for guided medical/surgical decision making
- ☐ an interest in receiving more information about their anticipated future health
- ☐ an interest in learning about options for integrating a palliative approach into existing therapies

All patients must be accompanied to clinic by a family member/caregiver.

| | | | |
|---|---|---|---|
| **DEMOGRAPHICS** | **Patient Name:** | | |
| | Health Card Number: | Tel: | DOB: |
| | **Primary family member/contact person:** | | |
| | Relationship: | Tel: | |
| | **Referring Physician:** | | |
| | □ Primary Care □ Pre-op □ Medical □ Surgery subspecialty: | Page/Contact number: | |
| **HEALTH INFORMATION** | Main health issue prompting referral | | |
| | Specific intervention being proposed (if applicable) | | |
| | Scheduled date for the intervention (if applicable) | | |
| | Current and past health conditions, including dementia (if previously diagnosed) | | |
| | □ FACT form attached (if done) □ Please attach any information that would be helpful | | |

**Patient/or caregiver consent:** The principles of the PATH clinic have been explained to me. More information is available to me at PATHclinic.ca. I agree to participate.

Signature: _____ Date: (YYYY-MM-DD)_____

**Referrals without patient (or caregiver where applicable) signature will not be accepted**



**Fax to: 902-473-7133**