Saint Elizabeth
Well beyond health care

Must be Indigenous, homeless / structurally vulnerable, palliative

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Palliative Mobile Outreach Nurse
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Referral Date: _____

Referral Source Name: _____ Phone number: _____

Client aware of referral: Yes No Client agrees to Referral: Yes No

Client's Name: _____ Health Card Number: _____

DOB (DMY) _____ Gender:_____ Marital Status: _____

Language spoken: _____ Interpreter Needed: Yes No

Affiliation: _____ Family Doctor: _____

Where is the client living: _____

Where would client like to be seen? _____

Best way to contact or find client: _____ Phone: _____

Visit with nurse alone: Yes No If no, whom would they like to be present? _____

Best day and time to do visit: _____

History / symptoms / medications:

Reason for Referral: include any orders

Urgency: today Within 24 hours Within 48 hours Other please specify:_____

What does client want/expect from visit :

Emergency contact: _____

Risk factors (alcohol, drugs, abuse, etc) _____

Any end of life planning started: Yes No DNR: yes no Deemed Palliative: Yes No Not sure