



## Palliative Care Social Work Referral Form

Individual must be registered with the Palliative Care Program  
Please **FAX** completed form to Palliative Care 204-388-2049

- Urgent - within two weeks
- Non Urgent - within two to three weeks
- Consult – indicate if consult is urgent or non-urgent

**If emergent, contact Crisis Response 1-888-617-7715**

<b>Palliative Care Client Name:</b>	
<b>Referral is for :</b>	
<input type="checkbox"/> Client    Diagnosis: _____	Palliative Performance Scale: _____
<input type="checkbox"/> Family Member    Name: _____	Relationship: _____
<input type="checkbox"/> Significant Other    Name: _____	Relationship: _____
<b>Contact Information:</b>	

Is this person aware of the referral/consult to the Palliative Care Social Worker?     Yes     No

**Please fill out the information below if known/pertinent for the individual being referred.**

Date of Birth: _____	PHIN: _____
<b>History of Mental Health Challenges:</b> _____	
Is this person seeing any other mental health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please provide name and contact information:	

### Referral Source

<input type="checkbox"/> Self	<input type="checkbox"/> Family Physician	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Personal Care Home	<input type="checkbox"/> Acute Care	<input type="checkbox"/> Home Care
<input type="checkbox"/> Cancer Care Manitoba	<input type="checkbox"/> Cancer Care Program	<input type="checkbox"/> Family / Friend
<input type="checkbox"/> Palliative Care Team Member	<input type="checkbox"/> Other:	
<b>Name:</b>		<b>Contact Information:</b>

### Reason for Referral

<input type="checkbox"/> Person is experiencing significant distress related to end of life	
<input type="checkbox"/> Anxiety, Depression or other mental health challenges	
<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Financial Support
<input type="checkbox"/> Children under the age of 18	<input type="checkbox"/> Bereavement

**Please provide details regarding the reason for referral:**