Palliative Medicine Referral → Dr. V. Maida

Patient's Name (please print) ______________________

Patient's Date of Birth (Day/Month/Year) ______________________

Patient's Address ______________________

Patient's Health Card Number ______________________

Patient's Telephone Number ______________________

A: REASON FOR REFERRAL:

B: GOALS/OBJECTIVES OF CARE:

☐Active & Aggressive Medical Micromanagement

☐Conservative Palliative Management (Pain & Symptom Management)

C: RELEVANT HISTORY

D: PHYSICAL EXAMINATION:

E: INVESTIGATIONS: (Attach relevant diagnostic and consultation reports)

F: MEDICATIONS:

REQUESTED BY: ____________________________ MD

TELEPHONE: ______________________

ADDRESS: __________________________________

PHYSICIAN # ______________________

SIGNATURE: ________________________________

DATE: ___________________________