Symptom Management and Palliative Outpatient Clinic (SMPCOC)

Label

☐ Saskatoon Cancer Centre Fax: 306-655-6435

Please print and reply to all questions. It is not necessary to phone.

Date: _____

Patient's name: _____ ☐ Male ☐ Female
Last Name First Name Initial

Address: _____

City/Town _____ Province: _____ Postal code: _____

Date of birth: _____ Health card number: _____
(mm/dd/yy)

Next of kin/Contact: _____ Phone: _____

Family physician: _____ Referring physician: _____

Diagnosis _____

Is the patient/family aware of the referral: ☐ No ☐ Yes Referral made by: _____

Does the patient require an interpreter: ☐ No ☐ Yes, language: _____

Does the patient have an infectious disease (e.g., MRSA, VRE, TB): ☐ No ☐ Yes, please indicate: _____

Has the patient previously been seen by palliative care: ☐ No ☐ Yes

Is the patient followed by palliative home care: ☐ No ☐ Yes

Does the patient have palliative care drug coverage: ☐ No ☐ Yes

Patient code status: ☐ Full code ☐ No CPR
☐ Advanced care plan
☐ Medical proxy

Type of service requested:

☐ Pain
☐ Nausea/vomiting
☐ Constipation
☐ Appetite
☐ Dyspnea
☐ End of life care
☐ Other _____

Current management of symptoms: _____

_____

_____

_____

_____