FONDATION LA TRAVERSÉE
Palliative Care Home

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5100 Montée Ryan, Mont-Tremblant, QC J8E 1S4

APPLICATION FORM

SOURCE OF THE APPLICATION: ☐ SAD ☐ GMF ☐ HOSPITAL ☐ Other: _____

PATIENT'S IDENTIFICATION

LAST NAME:	FIRST NAME:	
EMAIL:	PHONE:	
ADDRESS:		
CITY:	POSTAL CODE:	
DATE OF BIRTH:	SEX:	LANGUAGE:
HEALTH INSURANCE NUMBER:		
ALLERGIES:	INTOLERANCE:	
SIGNIFICANT PERSON #1:	RELATION:	
	PHONE:	
SIGNIFICANT PERSON #2:	RELATION:	
	PHONE:	
CONTACT PERSON FOR PHARMACY PAYMENTS (preferred payment method by credit card)	RELATION:	
	PHONE:	

CLINICAL INFORMATION

ATTENDING PHYSICIAN:	Family physician:	PHONE:
	Clinic:	PHONE:
	CLSC:	PHONE:
CLSC CONTACT NURSE:		PHONE:
PHARMACY:		PHONE: RAMQ: ☐ PRIVATE INS: ☐

MAIN DIAGNOSIS: HISTORY OF DISEASE/TREATMENTS RECEIVED TO DATE:

_____

_____

_____

Date of diagnosis: _____

Metastasis: ☐ No ☐ Yes Location: _____

Medical history:

_____

_____

Date of last treatments: of chemotx: _____ of radiotx: _____

Pacemaker/defibrillator: ☐ Yes ☐ No ☐ Active ☐ Deactivated (date: _____ ☐ Unknown)

CURRENT SYMPTOMS: **Are the symptoms well managed?** □ Yes □ No

□ Ascites □ Dyspnea at rest □ Moderate anorexia (few bites)

□ Incontinence: □ Urinary □ Fecal □ Severe anorexia (liquid only)

□ Nausea/Vomiting □ Cachexia

□ Oedema □ Delirium □ Wounds (specify) : _____

□ Pain difficult to control □ Sub-occlusion/Intestinal occlusion

□ Dysphagia □ Dyspnea on exertion

□ **wandering** Other: _____

SPECIAL CARE: Associated medical conditions (dressing, catheter, tracheostomy, colostomy, drain, gastrostomy, etc.):

_____

MOBILITY: _____ TECHNICAL ASSISTANCE: _____

Explained and signed do not resuscitate order: □ Yes □ No Date :

Level of care:

_____

PROGNOSIS ON FILE < 3 months: □ Yes □ No **(Attach medical note)**

□ < 1 week □ < 1 month □ < 2 months

LEVEL OF PERFORMANCE IN PALLIATIVE CARE **PPS**: _____ % (see attached appendix for help)

12. Active smoking: □ Yes □ No □ Patient/family informed politics at La Traversée: □ Yes □ No

Cannabis consumption: □ Yes □ No In which form _____

Prescription available: □ Yes □ No

Stable supply: □ Yes □ No

IMPORTANT DOCUMENTS TO ATTACH TO YOUR APPLICATION: if available

- Summary sheets of recent hospitalizations/medical notes (if relevant to the application and to help prioritize the application for admission)
- FADM Hospital medication profile or patient's community pharmacy
- Histo-pathological reports
- Reports or notes of relevant specialist consultations (radiotherapist, oncologist, etc.)

The patient and family members have been informed that if, during the stay, the patient's state of health stabilizes or improves, or if wandering behaviors develop, the medical team reserves the right to re-evaluate the pertinence of keeping the patient at the Palliative Care Home La Traversée. In the event of a relocation of the patient, a plan B must already be established with the attending physician and/or the care providers before the patient is admitted.

☐ Return to home ☐ Accommodation ☐ Other: _____

CONTACT DETAILS OF THE PERSON INVOLVED IN THE FILE:	
NAME: _____	PHONE: _____
Institution: _____	Date: _____

Please return the completed and signed form to:

admissions@fondationlatraversee.com