Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
*Caring for Health* | *À l'écoute de notre santé*

# Application for Enrollment
# WRHA Palliative Care Program

Enrollment on the WRHA Palliative Care Program is based on criteria found in this application. Criteria are based on the *WRHA Modified Supportive and Palliative Care Indicators Tool (SPICT)*.

- The entire form must be completed or it will be returned and not assessed. **Fax application to 204-237-9162**
- Each case will be reviewed for eligibility. Enrollment is not automatic.
- The ***Palliative Care Drug Access Program*** form ***MUST*** be attached
- If you are seeking only a consult for symptom management, a consult form can be sent instead of this form.
- This application is for adult and pediatric patients (some of the criteria may vary in the pediatric population).
- **If this requested assessment is urgent, call 204-237-2400 for more immediate assistance (or page a palliative care physician 24/7 via 204-237-2053).**

The following criteria ***must*** be met for enrollment. Check all that are relevant and submit application only if all are appropriate:

☐ Life limiting condition
☐ Estimated prognosis of 6 months or less
☐ Advanced Care Plan **Medical** or **Comfort** (patient accepts do not attempt resuscitation)
☐ Patient (or substitute decision maker where appropriate) aware of and agree with application

## Patient Information

Patient Name: _____ Current Location: _____ Phone: |_|_|_|-|_|_|_|-|_|_|_|_|

Patient Address: _____ Postal Code: |_|_|_|_|_|_|

Date of Birth: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y) PHIN: |_|_|_|_|_|_|_|_|_|_| MFRN: |_|_|_|_|_|_|_|

Primary Language of Communication: _____ Other Languages: _____ Interpreter: ☐ Yes ☐ No

Primary Alternate Contact: _____ Relationship: _____ Contact Number: |_|_|_|-|_|_|_|-|_|_|_|_|

Referring Practitioner: _____ Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Fax: |_|_|_|-|_|_|_|-|_|_|_|_|

Primary Care Provider: _____ Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Fax: |_|_|_|-|_|_|_|-|_|_|_|_|

## Clinical Information

Primary Diagnosis: _____ Date of Diagnosis: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)

Related Treatment History: _____

Other Medical Issues: _____

Active Symptom Issues: _____

Known History of Substance Use Disorder: ☐ Yes ☐ No If yes, details: _____

**Estimated Prognosis** based on observed rate of clinical change and illness trajectory

☐ less than 1 week ☐ less than 1 month ☐ 1 to 3 months ☐ 3 to 6 months ☐ over 6 months/unsure

**Ensure Included:**

☐ Palliative Care Drug Access Program Form (*https://wrha.mb.ca/files/palliative-care-drug-access-form.pdf*)
☐ Supporting documents (medications, diagnostic result, specialist assessments, blood work results)
☐ Completed 2-page application (see page 2)

**CONTINUE TO PAGE 2**

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# Application for Enrollment
# WRHA Palliative Care Program

**The following will assist assessment of eligibility for enrollment in the WRHA Palliative Care Program** (based on WRHA Modified SPICT)

***Check all that apply:***

- ☐ Unplanned hospital admission(s).
- ☐ Performance status is poor or deteriorating, with limited reversibility. (i.e. The patient stays in bed or a chair more than half the day).
- ☐ Depends on others for care due to increasing physical and/or mental health problems. The patient's caregiver needs more help and support.
- ☐ The patient has significant weight loss over the past few months, or remains underweight.
- ☐ Persistent symptoms despite optimal treatment of underlying condition(s)
- ☐ The patient (or caregiver) asks for palliative care.

**The following will assist assessment of eligibility for enrollment in the WRHA Palliative Care Program.**

***Check all below that apply to this patient:***

**Respiratory Disease:**

- ☐ Severe, chronic lung disease with breathlessness at rest or on minimal exertion between exacerbations, despite optimal medical management.

**Heart/Vascular Disease**

- ☐ Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal exertion, despite optimal medical management
- ☐ Severe, inoperable peripheral vascular disease

**Kidney Disease**

- ☐ Stage 4 or 5 chronic kidney disease (eGFR less than 30 mL/min) with deteriorating health.
- ☐ Kidney failure complicating other life limiting conditions or treatments.
- ☐ Stopping or not starting dialysis.

**Liver Disease**

- ☐ Cirrhosis
- ☐ Diuretic resistant ascites
- ☐ Hepato-renal syndrome
- ☐ Bacterial peritonitis
- ☐ Recurrent variceal bleeds
- ☐ Hepatic encephalopathy

**Dementia**

- ☐ Unable to dress, walk or eat without help
- ☐ Eating and drinking less, difficulty swallowing
- ☐ Urinary incontinence
- ☐ Not able to communicate by speaking, little social interaction
- ☐ Frequent falls and/ or fractured bones
- ☐ Recurrent febrile episodes or infections; aspiration pneumonia

**Neurological Disease**

- ☐ Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- ☐ Speech problems with increasing difficulty communicating and/or progressive difficulty swallowing.
- ☐ Recurrent aspiration pneumonia; breathless or respiratory failure.

**Cancer**

- ☐ Functional ability deteriorating due to progressive cancer.
- ☐ Too frail for or declines oncology treatment AND radiation treatments are for symptom control only.

**Other Conditions**

- ☐ Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available (or that is undesirable to the patient) would have a poor outcome.

Signature of Referring Physician/Nurse Practitioner

Printed Name and Designation

Date: D D M M M Y Y Y Y

# Manitoba
Health

# Palliative Care Drug Access Program Application

***The Palliative Care Drug Access Program's purpose is to facilitate access to eligible pharmaceuticals on a no cost basis to a terminally ill patient, who wishes to remain in the community as an alternative to requiring admission to a health care facility.***

## Section (A) Applicant's personal information (Please Print)

*I hereby request coverage under the Manitoba Health –Palliative Care Drug Access Program.*

| Surname | First Name | Middle Name |
|---|---|---|
| | | |

| Manitoba Health Registration Number | Personal Health Identification Number (PHIN) |
|---|---|
| | |

| Mailing Address | | |
|---|---|---|
| | | |
| **Postal Code** | **City/Town** | **Province** |
| | | |
| **Patient's Signature** | | **Date** |
| | | |

## To be completed by guardian, legal representative or parent (if patient is under the age of 18)

I am the Patient's: ☐ Guardian ☐ Legal representative ☐ Parent

| Surname | First Name | |
|---|---|---|
| | | |
| **Signature** | **Date** | **Telephone No.** |
| | | |

## Section (B) To be completed by the attending Physician

*I hereby certify that this patient meets the criteria for Palliative Care Drug Access Program.*

Patient's eligibility is contingent on meeting all enrolment criteria below :

- The applicant requires prescribed eligible pharmaceuticals to support the palliative care plan.
- The applicant's primary pharmaceutical needs are for comfort-focused care.
- The applicant and/or their family understand, and agree with the plan for comfort-focused care.

| Attending Physician's Name (Please Print) | Physician's License No. | Telephone No. |
|---|---|---|
| | | |

| Patient's Primary Diagnosis | Other Diagnosis |
|---|---|
| | |

| Signature | Date |
|---|---|
| | |

## Section (C) To be completed by the Regional Health Authority Palliative Care Coordinator or Regional Designate

The applicant is enrolled in a Regional Health Authority Palliative Care Program and is receiving program services.

| Palliative Program Enrolment Date: (dd/mm/yy) | Application Date to Drug Access Program:(dd/mm/yy) | Palliative Program Withdrawal Date: (dd/mm/yy) |
|---|---|---|
| | | |

| Palliative Coordinator Signature | Date | RHA No. | Telephone No. | Fax No. |
|---|---|---|---|---|
| | | | | |

| Date Received from RHA | Effective Date | Notification of Withdrawal from RHA Receive Date | |
|---|---|---|---|
| | | | |
| Date RHA Notified | Verified By | DPIN Validation Completed | Verified By |
| | | | |

***In order to process this application as quickly as possible, please ensure information required is complete.***

***11/02***

***(Français au verso)***