



WRH-MC - ER

Patient Demographics

Referral and Treatment Plan

- Chatham Site Sarnia Site Windsor Site
 Ph: 1-888-447-4468 Ph: 1-888-447-4468 Ph: 1-888-447-4468
 Fax: 1-844-858-3546 Fax: 1-844-858-3546 Fax: 1-844-858-3546

Patient Name: _____

M F DOB: _____
 (dd/mm/yy)

HCN: _____ VC: _____

Address/911: _____

City: _____ PC: _____

Phone: _____

Community: _____

Hospital: _____ Unit: _____

Alternative Contact for Patient: _____

Relationship: _____ Phone: _____

- Patient Agrees to Referral
- Service Needed:** (Assessment by HCCSS ESC to determine services in clinic or home)
- Nursing Palliative Care PSW Telehomecare Long Term Care Dietician Social Work PT OT SLP
 Behavioural Support Ontario (BSO)

Reason for Referral: _____

Diagnosis: _____

NKA Allergies/Sensitivities: _____

Medical Orders

Best practice/evidenced based practice will be initiated unless otherwise written. Wound care outside of evidenced based practice may not be eligible for HCCSS ESC services. Treatment will be taught and service reduced when appropriate.

- Specify Wound:** Surgical Malignant Pilonidal Traumatic Venous Leg Ulcer Arterial Leg Ulcer
- Diabetic Foot Ulcer Maintenance Non-Healing Other: _____ Pressure injury: Stage: 1 2 3 4
- IV Therapy:** Peripheral PICC Midline – Catheter Length: Internal: _____ cm External: _____ cm
- Subcutaneous Central Number of Lumens: 1 2 3

Drug: _____

Dose: _____ Frequency: q24h q12h q8h q6h q4h Other: _____

Duration of remaining community treatment: _____ Days (number of) or _____ Doses (number of)

Last Dose in Hospital: Date: (dd/mm/yy) _____ Time: _____ am pm N/A

Community Therapy to Start: Date: (dd/mm/yy) _____ Time: _____ am pm

Has received same medication and route within past 12 months
 Has NOT received medication within past 12 months - First Dose Parenteral Screener Completed
 REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines

Start time may be delayed up to 8 hours if the next dose due is between midnight to 0800h.

Additional Referral Information/ Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

Signature	Print Name/Designation/Title	OHIP Billing Code 1
CPSO/CNO Reg. Number	Phone Number	Date (dd/mm/yy)

¹Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.