Medical Referral Form Guidelines For Children (under 18 years)

Field	Content
Patient Demographics	Place an Addressograph Label or at least two patient identifiers (i.e., patient first and last name and Health Card Number)
Name	
Parent/Guardian	
Address	
City	
Postal Code	
Telephone	
DOB	
Sex	
HCN	
VER	
Weight & Height	Weight in kilograms; height in centimeters
Alternate Contact	Enter an alternate contact name and phone number
Allergies	Indicate allergies present, no known allergies, or unable to assess (consistent with information we collect for allergy information in CHRIS). If allergies are identified, write name of allergy and severity of reaction in Allergy Details.
Diagnosis	Enter Diagnosis most relevant to the referral Indicate 'yes' or 'no' as to if diagnosis was discussed with family/guardian/patient
Prognosis	Indicate whether the patient's condition is expected to improve, remain stable, deteriorate, or guarded. Curative Palliative or EOL are choices.
Other Diagnosis/Presenting Problems	Other diagnosis relevant to the presenting problem to be included
Surgical Procedure or Treatment	Enter type of surgical procedure or treatment and date
Current Medications	List medication(s) currently being taken by patient independent of Home and Community Care Support Services assistance OR attach medication list
Medication to be administered by Home and Community Care Support Services: Note: Same day medication orders must be received by Home and Community Care Support Services by 1300 hrs.	• Drug • Limited use code if needed • Dose, Frequency of administration, Route of administration **Mandatory Fields:** • Last dose given in Hospital: date and time • Next dose due in Community: date and time • Length of therapy in days
IV Route Access Device	Indicate the intravenous access device. Radiological confirmation of a new central line tip has been completed. Attach documentation
Heparinization Dosing Guidelines for Physician Reference	Guidelines are based on Hospital for Sick Children's protocols
Other Medical Orders	• Include all other medical orders here
Is this service requested at School	• Check yes or no; if yes, enter school name
Requested Services to be Assessed by Home and Community Care Support Services	Indicate services Home and Community Care Support Services to assess • If arranged with client by physician • If requesting in-home lab through Home and Community Care Support Services /need MOH requisition • Include comments with additional information if required
Signature of Physician / NP	Print and sign First name, and last name; include phone number, Date and CPSO#
Alternate Most Responsible Physician / Nurse Practitioner	Enter name and phone number of most responsible physician / nurse practitioner
Telephone Order from Physician / NP	Print first and Last name, phone number and date
Fax Completed - Referral Form to Home and Community Care Support Services	Include Date