



CKHA- OP

**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

Community: \_\_\_\_\_

Hospital: \_\_\_\_\_ Unit: \_\_\_\_\_

Alternative Contact for Patient: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

M     F      DOB: \_\_\_\_\_  
(dd/mm/yy)

HCN: \_\_\_\_\_ VC: \_\_\_\_\_

Address/911: \_\_\_\_\_

City: \_\_\_\_\_ PC: \_\_\_\_\_

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)