HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

Please return this form to the HCCSS South West via fax to:
London: 519-472-4045 (for clients living in London/Middlesex and Elgin counties)

Stratford 519-273-2847 or toll free: 1-855-223-2847 (for clients living in Grey/Bruce, Huron, Oxford, Perth)

Referral/Request for Assessment

This is a PDF Interactive form. You have the option to complete all or parts, electronically. When completed, please print and fax to HCCSS South West

Patient's Name*: _____	CELL/Alternate PATIENT Ph. No.: _____
Address*: _____	Alternate CONTACT Pers. Ph. No: _____
Postal code: _____	Date of Birth *d/m/y* _____
Phone number *: _____	**Health Card # *:** / **Version:**
Is patient aware of referral? ❑ Yes ■ No	
Significant Medical - Information/Symptoms	Communicable Diseases:

Diagnosis:

Surgical Procedure/Date *d/m/y* _____

Prognosis ☐ Improve ☐ Deteriorate ☐ Maintenance Diagnosis /Prognosis Discussed with Patient ☐ Yes ☐ No

Allergies:

TREATMENT ORDERS:

❑ HCCSS Assessment ❑ CCP (Coordinated Care Plan) Telehomecare ☐ COPD ☐ CHF

Other Treatment Orders:

Degree of Weight Bearing ☐ None ☐ Partial ☐ Full ☐Progression

TREATMENT ORDERS: WOUND CARE

Wound Dx: ☐ Maintenance ☐ Healable ☐ Non- healable

☐ **Wound Care:** Patient's receiving service within South West region will be provided wound care according to HCCSS South West Wound Care Management Program unless otherwise indicated.

Note: **1) Treatments will be taught and services reduced when appropriate**
2) Wound care orders outside of best practice may not be eligible for Home and Community Care Support Services South West services
3) Wound care products may be substituted to a comparable product based on HCCSS South West supply list

Compression Therapy requires ABPI measurements VLU ABPI_____ Date *d/m/y* _____

Referring Physician or Nurse Practitioner **Date:** *d/m/y*

Name (Print) **Signature:** **Telephone:**

Family Physician Name (Print)_____ ☐ or **Same as Referring Physician**

Form initiated by (if other than Referring Physician or Nurse Practitioner) **Date:** *d/m/y*

Name (Print) Position

Signature:_____ Telephone_____

* = mandatory fields. This form **must be signed and dated by the Referring Physician or Nurse Practitioner** at the time of referral, if treatment orders require such signature. Information entered by other than the physician must be signed and dated.