



ESHC - ER

Patient Demographics

Referral and Treatment Plan

- | | | |
|--|---|--|
| <input type="checkbox"/> Chatham Site
Ph: 1-888-447-4468
Fax: 1-844-858-3546 | <input type="checkbox"/> Sarnia Site
Ph: 1-888-447-4468
Fax: 1-844-858-3546 | <input type="checkbox"/> Windsor Site
Ph: 1-888-447-4468
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
 REMEDSIVIR: 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)