

Medical Referral

PATIENT DETAILS

(Patient Last Name, First Name) _____
 Home Address: _____ DOB (dd-mmm-yyyy): _____
 City: _____ Postal Code: _____ Home Phone: _____
 Health Card Number & Version Code: _____ Caseload: _____

DIAGNOSIS: 1) _____ 2) _____

Surgical Procedure/Treatment: _____ Date: _____
 (dd-mmm-yyyy)

Other Significant Medical Information:

Allergies: No Unknown Yes, Specify:

Multi-drug Resistant Organism (MRO): No Unknown Yes, Specify:

Diagnosis Discussed With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes	Prognosis: <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Unknown	Prognosis Discussed With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DNR Order in Place: <input type="checkbox"/> No <input type="checkbox"/> Yes
Diagnosis Discussed With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes		Prognosis Discussed With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes	

The Patient/SDM is aware of the prognosis and should death occur, Physician or Nurse Practitioner (NP) _____ has agreed to make a home visit and sign a death certificate or, will arrange for a Physician substitute in his/her absence - No Yes
 Palliative Performance Score (PPS): _____ Edmonton Symptom Assessment Scale (ESAS): _____

MEDICAL ORDERS

TREATMENT ORDERS

Weight Bearing (WB)

(**Mandatory for patients requiring therapy services)

	R	L		R	L
Full	<input type="checkbox"/>	<input type="checkbox"/>	Feather	<input type="checkbox"/>	<input type="checkbox"/>
Partial	<input type="checkbox"/>	<input type="checkbox"/>	Non-WB	<input type="checkbox"/>	<input type="checkbox"/>

INFUSION ORDER (**Mandatory Information)

Initial Dose: _____ Time: _____
 (dd-mmm-yyyy)

Next Dose in Home: _____ Time: _____
 (dd-mmm-yyyy)

Central Venous Lines:

Valved: No Yes Tip Confirmed: No Yes

Flushing Protocols:

Clinic/Follow-up Appointment: _____
 (dd-mmm-yyyy)

Lab Tests: Type, Frequency: _____

Results To: _____

Phone #: _____ Start Date: _____
 (dd-mmm-yyyy)

Diabetic: No Yes Beta Blockers: No Yes

Phone Order From Physician/NP: _____ To: _____ Date: _____
 (dd-mmm-yyyy)

SIGNATURE OF PHYSICIAN/NP: _____ Phone #: _____

Print Name: _____ Date: _____
 (dd-mmm-yyyy)

Care Coordinator: _____

Phone # and Extension: _____ Date: _____
 (dd-mmm-yyyy)

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CONTROLLED ACTS ARE AS FOLLOWS:

- Performing a prescribed procedure below the dermis or a mucous membrane
- Administering a substance by injection or inhalation
- Putting an instrument, hand or finger:
 1. beyond the external ear canal
 2. beyond the point in the nasal passages where they normally narrow
 3. beyond the larynx
 4. beyond the opening of the urethra
 5. beyond the labia majora
 6. beyond the anal verge
 7. into an artificial opening into the body
- Dispensing