Champlain LHIN
Medical Referral Form

Ontario
Local Health Integration Network

Name*
Address
Date of Birth
Phone*
HCN* / v.c.

Please Note: LHIN will only process completed referrals that have been signed and dated and are legible.

PROCEDURES WILL BE TAUGHT TO PATIENT OR RELIABLE PERSON

When appropriate THE PATIENT WILL BE REFERRED TO A Community Nursing CLINIC instead of a HOME VISIT

ALLERGIES:

INFECTION CONTROL PRECAUTIONS:
☐ DROPLET ☐ AIRBORNE ☐ CONTACT ☐ ROUTINE

Preferred language for service: FRE ☐ ENG ☐ Other ☐

Hospital Planned Discharge Date:

☐ Please use alternate contact (rather than the patient) for assessment, due to: ☐ Preference ☐ Hearing ☐ Cognitive ☐ Language ☐ Other

Alternate Contact Person: | **Relationship**: | **Phone:**

DIAGNOSIS:

WOUND: ☐ Initiate or Continue with LHIN wound care (based on RNAO best practice) protocol
Location and Measurements: Date of last dressing change:
Packing ☐ Yes ☐ No Type & Size of Packing: Length inserted:

PLEURAL EFFUSION / ABDOMINAL DRAINAGE FOR MALIGNANCIES ONLY (1): **Patient had pleuroscopy** ☐ Yes - insertion date:
☐ **Lung** ☐ **Abdomen** Drain up to mLs times a week & PRN **Remove sutures:** ☐ Yes Date: ☐ No ☐ Pleurex ☐ Other:

TOHCC CHIPP PROTOCOL (2): ☐ Yes -Tentative Start Date: See reverse for protocols

INDWELLING CATHETER (3): Insertion Date: Size: ☐Silicone-coated Latex ☐Latex ☐Silicone ☐Silastic
(Note: if size/type not specified, will default to #14/16 FR silicone coated latex catheter) ☐Other:

OTHER PROTOCOLS: ☐ **Nephrostomy Tube (4A)** | ☐ **Percutaneous Tube (4B)** Irrigation with NS Amount Frequency | ☐ **Ostomy care (5)** | **ADP Form completed?** ☐ YES ☐ NO | **Starter kit provided?** ☐ YES ☐ NO

OTHER ORDERS:

*****MANDATORY***** List all **medications for Medication Reconciliation Purposes**: use separate sheet if required

Physician/NP Name: (please print) | CPSO/college # *Required for Prescription Medications

Physician/NP signature: | Date:

If delegate, name of attending physician: | Telephone:

By signing this document, I (physician/NP) have reviewed the community protocol on the reverse of this form and agree with this procedure or have specified other procedure above.

Other Service Needs:

☐ **Physiotherapy**
Degree of Weight Bearing: ☐ None ☐ Partial ☐ Full ☐ Progression
Height (if walker req):

☐ **Occupational Therapy** ☐ **Speech** ☐ **Dietician** ☐ **Social work**

☐ **Personal Support Service**

Please attach hospital assessment information

☐ Linking to community resources/supports

Notes:

Name of Referring Health Professional: Date: Telephone #:

1) PLEURAL EFFUSION/ABDOMINAL DRAINAGE FOR MALIGNANCIES ONLY

Pleural CATHETER DRAINAGE

a) Complete drainage as per policy and procedure for lung or abdomen.

b) Do not drain more than 1000 mL per drainage procedure for the lung effusion or more than 4000 mL for the abdominal drainage, unless otherwise prescribed by physician.

c) If drainage is < 50 mL for 3 consecutive drains and the patient is not symptomatic, contact the Malignant Effusion Program for a follow-up appointment at (613-737-8899 extension 79987).

d) Discontinue drainage if patient experiences pain or dyspnea that is not relieved by slowing or stopping the drainage process.

Pleural CATHETER DRESSING CHANGE

a) Complete dressing change as per policy and procedure at the time of chest tube drainage and PRN.

b) If chest tube is not being drained, change dressing twice a week and PRN (e.g. non-occlusive or soiled).

c) If patient is allergic to dressing assess and page "Pleural Effusion Nurse On Call" at 613-737-8899

2) TOHCC CHIPP STANDING ORDERS

a) Initiate CHIPP Symptom Management Guidelines

b) Discontinue 5-FU infusion on the final day of radiation therapy

c) Patient will receive first nursing visit on day of disconnect regardless of duration of infusion.

CHIPP Infusor Orders:

a) If residual volume present at any time of disconnect, assess potential reasons for delay, provide appropriate patient education and return in five hours to disconnect.

b) If residual remains after additional five hours of infusion, notify PDN and Care coordinator, disconnect and complete the CHIPP Delay Infusion form

3) INDWELLING CATHETERS OR SUPRAPUBIC CATHETERS

a) Change **latex** catheter monthly and PRN

b) Change **silastic and silicone – silicone coated** catheters every 3 months and PRN

c) Irrigate catheter with 50-150mL Normal Saline PRN

If size/type not specified on medical referral, standard Foley catheter kit will be provided with #14/16 FR silicone coated latex catheter

4) PERCUTANEOUS TUBES

4A) NEPHROSTOMY TUBES

a) Using sterile procedure, irrigate the catheter with no more than 10mL of Normal Saline 2 x/wk and PRN (daily if patient or family can do it). **Do not aspirate**.

b) Clean catheter insertion site with non-alcohol Chlorhexidine and apply dressing (gauze and transparent dressing or drain attachment device and transparent dressing) weekly and PRN.

c) Change extension tubing, stopcock and bag every 2 weeks and PRN.

d) Monitor catheter insertion site for infection.

4B) PERCUTANEOUS TUBES (e.g. Biliary Catheter or Draining Abscess)

PHYSICIAN must specify amount and frequency of irrigation

a) Clean catheter insertion site with non-alcohol Chlorhexidine and apply dressing (gauze and transparent dressing or drain attachment device and transparent dressing) weekly and PRN.

b) Change extension tubing, stopcock and bag weekly and PRN.

c) Monitor catheter insertion site for infection.

5) OSTOMIES

New Ostomies: 4 visits over 6 weeks to **teach.** Supplies provided 30 days only.

Established Ostomies: Assess and address issue, then **teach & discharge.**

Supplies only provided if new product trial required or wound impacting flange, short-term only.