Print

Erie St. Clair **LHIN**

Referral and Treatment Plan

☐ Chatham Site
Ph: 1-888-447-4468
Fax: 519-351-5842

☐ Sarnia Site
Ph: 1-888-447-4468
Fax: 519-337-4331

☐ Windsor Site
Ph: 1-888-447-4468
Fax: 519-258-6288

Community:_____

Hospital:_____ Unit:_____

Alternative Contact for Patient: _____

Relationship:_____ Phone: _____

Patient Demographics

Patient Name:_____

☐ M ☐ F DOB: _____
(dd/mm/yy)

HCN:_____ VC: ____

Address/911:_____

City:_____ PC: _____

Phone: _____

☐ **Patient Agrees to Referral**

Service Needed: (Assessment by ESC LHIN to determine services in clinic or home)

☐ Health Links
☐ Nursing ☐ Palliative (PCCT) ☐ Personal Support ☐ Telehomecare ☐ Long Term Care Placement
☐ Dietician ☐ Social Work ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Language Pathology
☐ COPD Teams ☐ PCCT NP ☐ Rapid Response Nurse (RRN) ☐ Geriatric Rapid Response Team (GRRT)

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 ESC LHIN 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 Ulcer: **Specify Stage:** ☐ 1 ☐ 2 ☐ 3 ☐ 4

IV Therapy: ☐ Peripheral ☐ PICC - Catheter Length: Internal:_____cm External:_____cm
☐ Subcutaneous ☐ Central Number of Lumens: ☐ 1 ☐ 2 ☐ 3
First Dose Given: ☐ Yes ☐ No **Date and Time Next Dose Due:** _____

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)

[1]Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.