Connecting you with care
Votre lien aux soins
South West
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

Please return this form to the South West CCAC 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)

South West CCAC
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 CCAC.

Client's Name*: ______________________________________

Address*:____

Postal code:________________**Phone number *:** _____________

Is client aware of referral? ❑ Yes ❑ No

Alternate contact
Contact phone number (_______) ______________________

Date of Birth *d/m/y* ____________________________________

Health Card # *: ____________________ **Version:** _____

Significant Medical - Information/Symptoms

Communicable Diseases:

Diagnosis:

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

Allergies:

TREATMENT ORDERS:

Intravenous (IV) Antibiotics For LHSC Home Hemodialysis (HHD) Patients

1. Patient will perform hemodialysis (HD) machine setup as usual
2. CCAC RN will instruct/demonstrate how to use the Sapphire pump (RN has no responsibilities regarding the HD machine/procedure)
3. Set Sapphire pump to mL/hr mode and prime tubing
4. Patient to connect the tubing to the **venous medication line** on the HD machine (see HHD and IV Antibiotic Guide located on the CCAC portal). Ensure that the connection is secure
5. Patient will perform the HD procedure and administer the antibiotic at the specified time and duration
6. Patient's currently dialyzes:
   □ conventional (three times per week)
   □ intermittent (every other day)
   □ short hour daily: _____ times per week
   □ nocturnal: _____ times per week
   □ other: ____________________________

   Note: these patients are not appropriate for the flex clinic.

Referring Physician or Nurse Practitioner

______________________ ______________________ ______________
Name (Print) **Signature** **Telephone**

Date: *d/m/y* ____________

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

Form initiated by (if other than Referring Physician or Nurse Practitioner)

______________________ ______________________________
Name (Print) Position

Signature: ____________________________ Telephone______________________

Date: *d/m/y*

* = 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.