

**South West LHIN
Referral/Request for Assessment**

Please return this form to the South West LHIN 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)

*This is a PDF Interactive form. You have the option to
complete all or parts, electronically.
When completed, please print and fax to South West LHIN*

Patient's Name*: _____ Address*: _____ Postal code: _____ Phone number*: _____ Is patient aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	CELL/Alternate PATIENT Ph. No.: _____ Alternate CONTACT Pers. Ph. No: _____ Date of Birth d/m/y _____ Health Card #*: _____ Version: _____
Significant Medical - Information/Symptoms	Communicable Diseases:
Diagnosis:	
Surgical Procedure/Date d/m/y _____	
Prognosis <input type="checkbox"/> Improve <input type="checkbox"/> Deteriorate <input type="checkbox"/> Maintenance <input type="checkbox"/> Maintenance <input type="checkbox"/> Maintenance <input type="checkbox"/> Maintenance <input type="checkbox"/> Maintenance Diagnosis /Prognosis Discussed with Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies:	
TREATMENT ORDERS:	
<input type="checkbox"/> LHIN Assessment <input type="checkbox"/> CCP (Coordinated Care Plan) Telehomecare <input type="checkbox"/> COPD <input type="checkbox"/> CHF	
Other Treatment Orders:	
Degree of Weight Bearing <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/> Progression	
TREATMENT ORDERS: WOUND CARE	
Wound Dx: <input type="checkbox"/> Maintenance <input type="checkbox"/> Healable <input type="checkbox"/> Non- healable	
<input type="checkbox"/> Wound Care: Patient's receiving service within South West region will be provided wound care according to South West LHIN Wound Care Management Program unless otherwise indicated.	
Note: 1) Treatments will be taught and services reduced when appropriate 2) Wound care orders outside of best practice may not be eligible for South West LHIN services 3) Wound care products may be substituted to a comparable product based on South West LHIN supply list	
Compression Therapy requires ABPI measurements VLU ABPI _____ Date d/m/y _____	
Referring Physician or Nurse Practitioner	
Name (Print) _____	Signature: _____ Telephone: _____
Date: d/m/y _____	
Family Physician Name (Print) _____ <input type="checkbox"/> 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.