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

CELL/Alternate CLIENT 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 ☐ Improve ☐ Deteriorate ☐ Maintenance Diagnosis /Prognosis Discussed with Client ☐ Yes ☐ No

Allergies:

TREATMENT ORDERS:

❑ CCAC Assessment | ❑ CCP (Coordinated Care Plan) | Telehomecare ☐ COPD ☐ CHF

Other Treatment Orders:

Degree of Weight Bearing ☐ None ☐ Partial ☐ Full ☐Progression

TREATMENT ORDERS: WOUND CARE

Wound Dx: ☐ Maintenance ☐ Healable ☐ Non- healable

☐ **Wound Care:** Client's receiving service within South West region will be provided wound care according to South West CCAC 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 SW CCAC services
3) Wound care products may be substituted to a comparable product based on SW CCAC 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)______________________________ ☐ 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.