



ESHC - OP

Referral and Treatment Plan

- Chatham Site Sarnia Site Windsor Site
 Ph: 1-888-447-4468 Ph: 1-888-447-4468 Ph: 1-888-447-4468
 Fax: 1-844-858-3546 Fax: 1-844-858-3546 Fax: 1-844-858-3546

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 HCCSS ESC to determine services in clinic or home)

- Nursing Palliative Care PSW Telehomecare Long Term Care Dietician Social Work PT OT SLP
 Behavioural Support Ontario (BSO)

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 HCCSS ESC 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 injury: Stage: 1 2 3 4

IV Therapy: Peripheral PICC Midline – Catheter Length: Internal: _____ cm External: _____ cm

Subcutaneous Central Number of Lumens: 1 2 3

Drug: _____

Dose: _____ Frequency: q24h q12h q8h q6h q4h Other: _____

Duration of remaining community treatment: _____ Days (number of) or _____ Doses (number of)

Last Dose in Hospital: Date: (dd/mm/yy) _____ **Time:** _____ am pm N/A

Community Therapy to Start: Date: (dd/mm/yy) _____ **Time:** _____ am pm

Has received same medication and route within past 12 months

Has NOT received medication within past 12 months - First Dose Parenteral Screener Completed

REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines

Start time may be delayed up to 8 hours if the next dose due is between midnight to 0800h.

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)