Medical Referral

Tel: (705) 721-8010 Toll free 1-888-721-2222 **Fax:** (705) 792-6270 Toll Free 1-866-700-1955

Diagnosis:	**Patient Identification**:
Surgical Procedure/Date (if applicable)**:**	Name (surname, first name):
Reason for Referral:	Address:
Other Relevant Medical Hx:	City: Postal code:
	Phone number: DOB (yyyy/mm/dd):
Communicable Diseases: ◯ n/a ◯ yes specify:	HCN: VER:
	Alternate contact: Phone #:
	***Mandatory if patient has cognitive impairment**

☐ Medication List attached ☐ Cumulative Patient Profile in Family Practice attached ☐ Patient is homebound

Allergies:

Prognosis: ◯ Less than 1 year ◯ Greater than 1 year Dx discussed with pt: ◯ yes ◯ no

***Same day medication orders must be received by Home and Community Care Support Service by 1300hrs**

Medication to be administered by Home and Community Care Support Services	**Limited Use(LU) Code**	**Dosage**	**Frequency**	**Route**	**Last Dose in Hospital: Date/Time**	**Next Dose in Community: Date/Time**	**Length of Therapy to be Given by HCCSS in Days**	**Lab (result, monitor plan & requisition)**

Best Practice Guidelines for IV Management will be followed unless specific orders are specified
IV Route Access Device: ☐ Peripheral ☐ CVAD ☐ IVAD - Type**:** _____
New Central Line Tip Confirmed ◯ Yes (Documentation attached) ◯ Yes ◯ No
1. Peripheral: 3mL N/S pre & post access; **2. Non-Valved CVAD & IVAD:** 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant **3. Valved CVAD:** Flush and lock with 10-20mL N/S after each access; weekly if dormant; **4. IVAD non-valved**: 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; **5. IVAD Valved**: flush and lock with 10-20mL saline
Medication doses can be staggered to accommodate clinic hours ◯ Yes ◯ No
Catheter re-insertion if patient unable to void following removal ◯ Yes ◯ No

Service Requested	*Note: Treatments will be taught and services reduced when appropriate*
☐ Nursing - Wound Care* ***NSM has a clinic first approach; all nursing will be seen at a clinic unless patient is home bound and therefore unable to physically attend appointments outside of the home**	*NOTE: Wound care orders outside of best practice may not be eligible for Home and Community Care Support Services. Wound care products may be substituted to a comparable product based on Home and Community Care Support Services supply list* Wound Type: _____ **Any specific instructions:**
	Compression Therapy requires ABPI measurements ABPI _____ Date: _____ YYYY/MM/DD
☐ Nursing – Other ***Please see above re clinic first approach***	

☐ Telehomecare (Must have diagnosis of COPD or CHF noted)

☐ **Lab** - Must attach Ministry of Health Lab requisition to this referral - for patients receiving in-home nursing/therapy

☐ Personal Support (e.g., bathing, dressing, etc.)

☐ Dietician ☐ Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect)

Therapies - must be necessary to enable the patient to remain in their home or enable them to return home.

Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy)

Degree of Weight Bearing: ◯ None ◯ Partial ◯ Full ◯ Progression

Referring Physician/Nurse Practitioner
Name (print)**:** _____
Signature: _____
Phone: _____ CPSO #_____ Date: _____ YYYY/MM/DD

Alternate Most Responsible Physician/Nurse Practitioner
Name (print)**:** _____
Phone: _____

Clear Form