HOME AND COMMUNITY CARE SUPPORT SERVICES
Erie St. Clair

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Érié St-Clair

CKHA-ER

Referral and Treatment Plan

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

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

☐ Windsor Site
Ph: 1-888-447-4468
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

Complete first dose Parenteral Medication Screener for all first dose orders.

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)

[1]Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.