



BWH - ER

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: 519-351-5842 Fax: 519-337-4331 Fax: 519-258-6288

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)

☐ Health links ☐ Nursing ☐ Palliative Care ☐ PSW ☐ Telehomecare ☐ Long Term care ☐ Dietician ☐ Social Work
☐ PT ☐ OT ☐ SLP ☐ e-Clinic (CKHA) ☐ 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 ☐

Additional Referral Information/ Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

☐ **Start time may be delayed up to a max of 8hrs (recommended when 'Therapy to Start' time falls between 0000-0800 to avoid return to ED)**

Signature

Print Name/Designation/Title

OHIP Billing Code 1

CPSO/CNO Reg. Number

Phone Number

Date (dd/mm/yy)