**HOME AND COMMUNITY CARE SUPPORT SERVICES**
Erie St. Clair

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

ESHC - OUTPATIENT

# Referral and Treatment Plan

☐ Chatham Site
Ph: 1-888-447-4468
Fax: 519-351-5842

☐ Sarnia Site
Ph: 1-888-447-4468
Fax: 519-337-4331

☐ Windsor Site
Ph: 1-888-447-4468
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) |

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