



**WRH-MC OUTPATIENT - URO**

**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)**