Home and Community Care Support Services
North Simcoe Muskoka

Medical Referral Form Guidelines
For Adult Patients

Field	Content
Patient Demographics	Place an Addressograph Label or at least two patient identifiers (i.e., patient first and last name and Health Card Number)
Patient Name	
Address	
City	
Postal Code	
Telephone	
DOB (yyyy/mm/dd)	
HCN	
VER	
Alternate Contact & phone #	Enter an alternate contact name and phone number
Diagnosis; surgical procedure and date; reason for referral; other relevant diagnoses	• Enter diagnosis most relevant to the referral • Enter the surgical procedure or treatment and date • Enter other relevant medical hx
Communicable Diseases	• Answer yes or n/a; enter any communicable diseases if yes
Medication List:	• Check if list attached
Cumulative Patient Profile in Family Practice attached	• Check if profile is attached
Patient is homebound	• Check if patient is homebound
Allergies	• Enter all known allergies
Prognosis	• Note whether the patient's prognosis is less than 1 year OR greater than 1 year • Indicate 'yes' or 'no' as to if prognosis was discussed with patient/ family
Medication to be administered by Home and Community Care Support Services: Note: Same day medication orders must be received by Home and Community Care Support Services by 1300 hrs.	Include: drug, limited use code (if needed), dose, frequency and route of administration **Mandatory Fields:** • **Last dose given in Hospital: date and time** • **Next dose due in Community: date and time** • **Length of therapy to be given by Home and Community Care Support Services in days** • **Lab (result, monitor play & requisition)**
Best Practice Guidelines for IV Management will be followed unless specific orders are specified:	Best Practice Protocols (information only)
IV Route Access Device	Check IV appropriate Access Route box
New Central Line Tip Confirmed	• Check box that tip was confirmed at time of insertion in radiology • If documentation is available please send
Medication doses can be staggered to accommodate clinic hours	• Answer yes/no
Catheter re-insertion if patient unable to void following removal	• Answer yes/no
Service Requested	• Treatments will be taught and services reduced when appropriate
Nursing Wound Care	• Indicate wound

Ontario

Field	Content
	• When appropriate indicate last ABPI measurement and date
Nursing – Other	• Enter all other nursing orders
Other Services Requested	Check appropriate service(s): • Telehomecare • Lab • Personal Support • Dietician • Social Work • Therapies
Degree of Weight Bering	If ordering Physiotherapy indicate the patient's weight bearing status
Referring Physician/Nurse Practitioner	Print and sign first name, last name and include phone number, date and CPSO#
Alternate Most Responsible Physician / Nurse Practitioner	Print first name, last name and include phone number and date