HOME AND COMMUNITY CARE SUPPORT SERVICES
Central West

MEDICAL REFERRAL
Hospital
Fax: 905-796-4677
Phone: 905-796-4687 / 1-833-229-5446

Addressograph or Label

Confirmed Discharge Date:_____or within: ☐ 24 hrs ☐ 48 hrs ☐ 72 hrs ☐ Other

Diagnosis:	**Allergies:**	**Precautions:** ☐ Contact ☐ Droplet/Contact ☐ Droplet ☐ Airborne **Reason for isolation:**

Prognosis (i.e. Months):

Discussed Care Plan with Patient/Caregiver ☐ Yes ☐ No
Discussed Care Plan with Primary Care Provider ☐ Yes ☐ No ☐ N/A

Palliative Performance Scale (0-100%): % ☐Improve ☐Remain Stable ☐ Maintenance ☐ Deteriorate

Service Requested	*Note: Eligible patients will receive nursing services within a clinic setting*

Nursing: Wound Care
As per Integrated Wound Care Pathways

☐ Pilonidal Sinus	☐ Diabetic Foot Ulcer	☐ Pressure Injury (Stage_____)	☐ Maintenance/Chronic Arterial Ulcer	
☐ Venous leg Ulcer	☐ Surgical Acute	☐ Lymphedema	☐ Non-Complex Burn	D Skin Tear
☐ Cellulitis	☐ Surgical Chronic	☐ Trauma	☐ Other: _____	

Compression Therapy for VIU - requires recent measurements: (ABPI) _____ Date: _____

NOTE: Wound care products may be substituted with a comparable product based on Home and Community Care Support Services Central West supply list.

Other - refer to '"Additional Orders1

☐ **Nursing: Specialty**	☐ Rapid Response Nurse ☐ NP-Palliative - Reason for Referral to NP:_____
☐ **Nursing: General**	☐ Ostomy Care/teaching ☐ Drain Care/Teaching ☐ Catheter Care/Teaching ☐ Enteral Feed ☐ Palliative Care ☐ Symptom Management ☐ Other: _____

ADDITIONAL ORDERS *(attach additional information as needed):*

☐ **Nursing: IV Medication #1**	**Drug**	**Dose**	**Route**	**Frequency**
	Duration	**First dose given in hospital?** ☐ **Yes** ☐ **No**	***Time of administered last dose:**	
☐ **Nursing: IV Medication #2**	**Drug**	**Dose**	**Route**	**Frequency**
	Duration	**First dose given in hospital?** ☐ **Yes** ☐ **No**	***Time of administered last dose:**	

COVID-19 Therapeutics (Remdesivir)

☐ Patient qualifies for REMDESIVIR treatment as per **Ontario Health guidelines.** Date of COVID-19 symptom onset:_____
☐ Remdesivir - 200 mg IV on Day 1, 100 mg IV daily on days 2 and 3

Is this a first dose? Yes ☐ No ☐ If no, Dose 1 date_____ ; Dose 2 date _____

☐ **Nursing: IV Hydration**

Solution:_____ Rate:_____ Duration:_____ Start:_____

☐ **Nursing: Central Lines (Adults)**

☐ **PICC line flush orders:** Flush and lock each lumen with 10 ml NaCl 0.9% post infusion, weekly and PRN.

Insertion Date: _____

☐ **Central venous line dressing orders:** Cleanse site with chlorhexidine and apply op-site weekly and PRN, change cap weekly.

☐ **Port-a-Cath care orders:** Flush and lock port-a-cath with 10 ml NaCl 0.9%. Flush q 1 month when not in use using a non-coring needle.

☐ **Tunneled catheter (e.g. Hickman) flush orders:** Flush and lock each lumen with 10 ml NaCl 0.9% weekly.

☐ **Additional Recommendations (e.g. OT, PT, Pharmacy Consult, etc.)** **Weight bearing status:**

***Note:** Eligibility and availability to be assessed and determined by a Home and Community Care Support Services Central West Care Coordinator **(attach additional information as needed).**

Patient has been informed to follow up with their Primary Care Provider: ☐ **Yes, within**_____**days** ☐ **No** ☐ **N/A**

Referring Physician/Nurse Practitioner/Other
Name (Print): **Signature:**
Designation: **Telephone**:

OHIP Billing #

DD/MM/YY