**HOME AND COMMUNITY CARE SUPPORT SERVICES**

**North Simcoe Muskoka** Page 1 of 1

**Medical Referral**

**Tel:** (705) 721-8010 Toll free 1-888-721-2222 **Fax:** (705) 792-6270 Toll Free 1-866-700-1955

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis:** | | | | | | | | **Patient Identification**: | | | | | | | | | | | | |
| **Surgical Procedure/Date** (if applicable)**:** | | | | | | | | Name (surname, first name): | | | | | | | | | | | | |
| **Reason for Referral:** | | | | | | | | Address: | | | | | | | | | | | | |
| Other Relevant Medical Hx: | | | | | | | | City: | | | | | | Postal code: | | | | | | |
| Phone number: | | | | | | DOB (yyyy/mm/dd): | | | | | | |
| Communicable Diseases:  n/a  yes specify: | | | | | | | | HCN: | | | | | | | | | | VER: | | |
| Alternate contact:  **\*Mandatory if patient has cognitive impairment** | | | | | | | | Phone #: | | | | |
| Medication Listattached  Cumulative Patient Profile in Family Practice attached  Patient is homebound | | | | | | | | | | | | | | | | | | | | |
| **Allergies:** | | | | | | | | | | | | | | | | | | | | |
| **Prognosis:**   Less than 1 year  Greater than 1 year Dx discussed with pt:  yes  no | | | | | | | | | | | | | | | | | | | | |
| **\*Same day medication orders must be received by Home and Community Care Support Service by 1300hrs** | | | | | | | | | | | | | | | | | | | | |
| **Medication to be administered by Home and Community Care Support Services** | **Limited Use(LU) Code** | **Dosage** | | **Frequency** | | **Route** | | | **Last Dose in Hospital: Date/Time** | **Next Dose in Community: Date/Time** | | | **Length of Therapy to be Given by HCCSS in Days** | | | | | | | **Lab (result,**  **monitor plan**  **& requisition)** |
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| **Best Practice Guidelines for IV Management will be followed unless specific orders are specified** | | | | | | | | | | | | | | | | | | | | |
| IV Route Access Device:  Peripheral  CVAD  IVAD - Type**:** | | | | | | | | | |  | | | | | | | | | | |
| **New Central Line Tip Confirmed**   **Yes (Documentation attached)**   **Yes**  **No**  **1.** **Peripheral:** 3mL N/S pre & post access; **2.** **Non-Valved CVAD & IVAD:** 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant **3.** **Valved CVAD:** Flush and lock with10-20mL N/S after each access; weekly if dormant; **4.** **IVAD non-valved**: 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; **5.** **IVAD Valved**: flush and lock with 10-20mL saline  **Medication doses can be staggered to accommodate clinic hours**  Yes  No  **Catheter re-insertion if patient unable to void following removal**  Yes  No | | | | | | | | | | | | | | | | | | | | |
| **Service Requested** | | *Note: Treatments will be taught and services reduced when appropriate* | | | | | | | | | | | | | | | | | | |
| Nursing - Wound Care\*  **\*NSM has a clinic first approach; all nursing will be seen at a clinic unless patient is home bound and therefore unable to physically attend appointments outside of the home** | | *NOTE: Wound care orders outside of best practice may not be eligible for Home and Community Care Support Services. Wound care products may be substituted to a comparable product based on Home and Community Care Support Services supply list* | | | | | | | | | | | | | | | | | | |
| Wound Type: | | |  | | | | | | | | | | | | | |  | |
| **Any specific instructions:** | | | | | | | | | | | | | | | | | | |
| Compression Therapy requires ABPI measurements | | | | | | | | | ABPI |  | | | Date: | |  | | | |
|  | | | YYYY/MM/DD | | | |
| Nursing – Other  \***Please see above re clinic first approach\*** | |  | | | | | | | | | | | | | | | | | | |
| Telehomecare (Must have diagnosis of COPD or CHF noted) | | | | | | | | | | | | | | | | | | | | |
| **Lab** - Must attach Ministry of Health Lab requisition to this referral - for patients receiving in-home nursing/therapy | | | | | | | Personal Support (e.g., bathing, dressing, etc.) | | | | | | | | | | | | | |
| Dietician  Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect) | | | | | | | | | | | | | | | | | | | | |
| **Therapies - must be necessary to enable the patient to remain in their home or enable them to return home.** | | | | | | | | | | | | | | | | | | | | |
| Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy) | | |  | | | | | | | | | | | | | | | | | |
| Degree of Weight Bearing:  None  Partial  Full  Progression | | | | | | | | | | | | | | | | | | | | |
| **Referring Physician/Nurse Practitioner**  **Name** (print)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone:** (\_\_\_\_) (\_\_\_\_)-(\_\_\_\_\_\_) CPSO #\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_  YYYY/MM/DD | | | | | | | | **Alternate Most Responsible Physician/Nurse Practitioner**  **Name** (print)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone:** (\_\_\_\_) (\_\_\_\_)-(\_\_\_\_\_\_) | | | | | | | | | | | | |