**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

|  |  |
| --- | --- |
| **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)** |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
| **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:** (\_\_\_\_) (\_\_\_\_)-(\_\_\_\_\_\_)  |