**HOME AND COMMUNITY CARE SUPPORT SERVICES**

**North Simcoe Muskoka** Page 1 of 1

**Medical Referral** - **Paediatric (under 18 years of age)**

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| **HOME AND COMMUNITY CARE SUPPORT SERVICES North Simcoe Muskoka** | **Paediatric Demographics** |
| 15 Sperling Drive, Barrie, ON L4M 6K9 | Name:       |
| Tel: (705) 721-8010 Toll Free 1-888-721-2222  | Parent/Guardian Name:       |
| **Fax: (705) 792-6270** | Address:       |
|  | City:       | Postal Code:       |
| **Patients may have care in a** [**nursing clinic**](http://healthcareathome.ca/nsm/en/Getting-Care/Getting-Care-in-Community/community-nursing-clinics) **and be taught their** | Phone:       | DOB: (yyyy/mm/dd)       | Sex:       |
| **treatments based on nurses discretion.** | HCN:       | Ver:       |
| **This document will be included in the Patient record.** | **Weight:**       | **Kg** | **Height:**       **cm** |
|  | Alternate Contact Name:       |
|  | Alternate Contact Phone:       |
| **Allergies:** (drug, environmental, animal, food)       |
| **Diagnosis:** (most relevant to care in community)      |
| **Diagnosis discussed with** Family/Guardian [ ]  Yes [ ]  No Patient [ ]  Yes [ ]  No |
| **Prognosis:** (Improve, Remain stable, Deteriorate, Guarded)       |
| **Prognosis discussed with** Family/Guardian [ ]  Yes [ ]  No Patient [ ]  Yes [ ]  No |
| **Other Diagnosis/Presenting Problem:**       |
| **Surgical Procedure or Treatment:**       |
| **Current Medications:** [ ]  (attach current list) N/A [ ]  | **\*Same day medication orders must be received by Home and Community Care Support Services by 1300 hrs** |
| **Medication to be administered**  | **Limited Use(LU) Code** | **Dosage** | **Frequency** | **Route** | **Last Dose in Hospital: Date/Time** | **Next Dose in Community: Date/Time** | **Length of Therapy in Days** |
|       |       |       |       |   |       |       |       |
|       |       |       |       |   |       |       |       |
| **IV Route Access Device:** [ ]  Peripheral [ ]  CVAD single lumen [ ]  CVAD double lumen[ ]  Implanted Vascular Device Type/Comment:       Is there Radiological confirmation of tip placement of new central line? [ ]  Yes **(Documentation attached)**   | **Heparinization Dosing Guidelines Reference:** |
| **Weight** | **Dose of Heparin** | **Heparin Product used** | **Total volume** | **Minimum Frequency** | **Maximum Frequency** |
| **Less than or equal to 10kg** | **10 units/kg** | **Dilute heparin 100units/mL with normal saline to total volume of 1 mL** | **1mL each lumen** | **Every 24 hours** | **Three times daily**  |
| **Greater than 10kg** | **100 units/kg** | **100 units/mL** | **1mL each lumen** | **Every 24 hrs** | **Three times per day if patient is receiving a systemic anti-coagulation** |
| **Other Medical Orders:**       |
| **Requested Services to be Assessed by Home and Community Care Support Services:**  |
| [ ]  Nursing [ ]  Physiotherapy [ ]  Occupational Therapy[ ]  Speech Therapy [ ]  Dietician [ ]  Social Work |
| [ ]  Respiratory Therapy [ ]  Lab (Patient has requisition and instructions) Comments:       |
| **Signature of Physician/Nurse Practitioner:**  |
| Print Name: Signature: Phone: Date: CPSO #: |
| **Alternate Most Responsible Physician/Nurse Practitioner:**Name: Phone:  |
| **Telephone Order From Physician/Nurse Practitioner:** |
| Taken By (print): Signature: Phone: Date of telephone order: |
| Fax completed **Home and Community Care Support Services** referral form to **(705) 792-6270** on: |