**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: | | | | | | | | | | | | | | | | | | | |