Request for Assessment

Phone: 800-263-3877 Fax: 855-352-2555

Name:		
Address:		**Postal Code:**
Sex: ☐ **M** ☐ **F** ☐ **undifferentiated** ☐ **unknown**	**Date of Birth:**	**Phone:**
HCN:		**Version Code:**

PRIMARY CARE PROVIDER

Name:	Phone:
If patient is in hospital, please indicate hospital site:	

PRIMARY DIAGNOSIS

	Diabetic: ☐ **Yes** ☐ **No**

IF CANCER DIAGNOSIS OR A LIFE LIMITING ILLNESS

Metastatic Spread: ☐ Yes ☐ No ☐ Describe:

Ongoing Treatment: ☐ Palliative ☐ Curative	Anticipated Prognosis: ☐ 0 <6 months ☐ 6-12 months ☐ Uncertain

OTHER DIAGNOSIS PERTINENT TO CARE

Allergies:

REASON FOR REFERRAL

☐ Case Management Assessment Request	☐ Other:
Surgical Procedure:	Date of Surgery:
Hospital:	
Is Patient/Family Aware of Referral: ☐ Yes ☐ No	
Telehomecare: ☐ Yes ☐ No	Related to: ☐ COPD ☐ CHF

MEDICAL ORDERS

Medical Treatment orders must be signed by an Ordering Physician/Nurse Practitioner

NOTE: There are specific forms for: • Infusion Therapy • Narcotic Infusion Therapy

Patient will be assessed for Nursing Clinic as appropriate for their treatment location

☐ **PRINT FOR SIGNING & FAXING**

ORDERING PHYSICIAN/NURSE PRACTITIONER

CPSO/ CNO#:

Print Name:

Signature:

Date:

CONTACT INFORMATION FOR ORDERING PHYSICIAN

Phone:

Fax:

After Hours:

☐ **PRINTABLE COPY**

Ontario