HOME AND COMMUNITY CARE SUPPORT SERVICES
Erie St. Clair

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Érié St-Clair

BWH - OP

# Referral and Treatment Plan

☐ Chatham Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

☐ Sarnia Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

☐ Windsor Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

Community:_______________________________________

Hospital:_________________________Unit:________________

Alternative Contact for Patient: ____________________________

Relationship:____________________Phone: __________________

**Patient Demographics**

Patient Name:_____________________________

☐M ☐F DOB:__________________ (dd/mm/yy)

HCN:________________________VC:_________

Address/911: ______________________________

City: ________________PC:_______________

Phone:__________________________________

☐Patient Agrees to Referral

**Service Needed:** (Assessment by HCCSS ESC to determine services in clinic or home)

☐Nursing ☐Palliative Care ☐PSW ☐Telehomecare ☐Long Term Care ☐Dietician ☐Social Work ☐ PT ☐OT ☐SLP

☐Behavioural Support Ontario (BSO)

Reason for Referral:__________________________________________________________

Diagnosis:______________________________________________________________

☐ NKA ☐Allergies/Sensitivities:______________________________________________

**Medical Orders**

***Best practice/evidenced based practice will be initiated unless otherwise written. Wound care outside of evidenced based practice may not be eligible for HCCSS ESC services. Treatment will be taught and service reduced when appropriate.***

**Specify Wound:** ☐Surgical ☐Malignant ☐Pilonidal ☐Traumatic ☐Venous Leg Ulcer ☐Arterial Leg Ulcer

☐ Diabetic Foot Ulcer ☐Maintenance ☐Non-Healing ☐Other:____________Pressure injury: Stage: ☐1 ☐2 ☐3 ☐4

**IV Therapy:** ☐Peripheral ☐PICC ☐Midline – Catheter Length: Internal:____________ cm External:____________ cm

☐ Subcutaneous ☐Central Number of Lumens: ☐1 ☐2 ☐3

**Drug**: ________________________________________________________________________

**Dose:** _____________Frequency: ☐ q24h ☐ q12h ☐ q8h ☐ q6h ☐ q4h Other:_________________

**Duration of remaining community treatment:**____________Days (number of) or_____________ Doses (number of)

**Last Dose in Hospital: Date**: (dd/mm/yy)____________________Time:____________☐ am ☐ pm ☐ N/A

**Community Therapy to Start:** Date: (dd/mm/yy)____________________Time:____________☐am ☐ pm

***☐Has received same medication and route within past 12 months***

***☐Has NOT received medication within past 12 months - First Dose Parenteral Screener Completed***

***☐REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines***

**Start time may be delayed up to 8 hours if the next dose due is between midnight to 0800h.**

Additional Referral Information/ Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

| **Signature** | **Print Name/Designation/Title** | **OHIP Billing Code 1** |
|---|---|---|
| CPSO/CNO Reg. Number | Phone Number | Date (dd/mm/yy) |

[1]Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.