

Fax to:

Kirkland Lake 705 567 9407	North Bay 705 474 0080	Parry Sound 1 855 773 4056	Sault Ste. Marie 705 949 1663	Sudbury 705 522 3855	Timmins 705 267 7795
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<input type="checkbox"/> PATIENT IS AGREEABLE TO REFERRAL.					
Health Card Number:		Version Code:		Date of Birth (DD/MM/YYYY):	
Surname:		First name(s):			
Address:		City:		Province:	Postal Code:
Phone #:		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify):			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown		Weight (kg):		Height (cm):	
Name of Contact Person (if other than Patient):					
Phone #:		Relationship: <input type="checkbox"/> POA/SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify):			
Relevant diagnosis:			Reason for Referral:		
Prognosis: <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate		Planned Hospital Discharge Date (DD/MM/YYYY):			
Location and Type of wound (if any):					
Infection control: <input type="checkbox"/> MRSA Positive <input type="checkbox"/> VRE Positive <input type="checkbox"/> C-diff <input type="checkbox"/> TB <input type="checkbox"/> Other (Specify):					
Surgical Procedure:			Surgical Date (DD/MM/YYYY):		
Weight bearing status: <input type="checkbox"/> Full-weight <input type="checkbox"/> Non <input type="checkbox"/> Partial		Activity/Mobility Restrictions:			
SERVICES REQUESTED					
<input type="checkbox"/> Nursing			<input type="checkbox"/> Enterostomal Therapist/NSWOC		
<input type="checkbox"/> Personal Support			<input type="checkbox"/> Rapid Response Nursing (Sudbury, Manitoulin, Espanola, North Bay, Sault Ste. Marie, Timmins, Parry Sound)		
<input type="checkbox"/> Occupational Therapy			<input type="checkbox"/> Telehomecare Nursing		
<input type="checkbox"/> Physiotherapy			<input type="checkbox"/> Social Work		
<input type="checkbox"/> Dietetics			<input type="checkbox"/> Speech-Language Pathology		
<input type="checkbox"/> NP Primary Care (Sudbury, North Bay, Sault Ste. Marie) <input type="checkbox"/> NP Palliative Care (Sudbury, Manitoulin, West Nipissing, Kirkland Lake, Sault Ste. Marie, Timmins)					
<input type="checkbox"/> Community Transition Nursing (Sudbury, Espanola, Parry Sound, North Bay, Kirkland Lake, Timmins, Sault Ste. Marie)					
INFUSION THERAPY ORDERS: Care Coordinator will coordinate pharmacy dispensing. Radiologic Report confirming PICC line placement is required.					
MEDICATION #1: Drug:		Dose:		Frequency:	
Route: <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Central Line type:		# Lumens:			
Date/Time Initial Dose Given (DD/MM/YYYY):		Date/Time Next Dose Due (DD/MM/YYYY):			
# Days Remaining:		Limited Use Code:			
MEDICATION #2: Drug:		Dose:		Frequency:	
Route: <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Central Line type:		# Lumens:			
Date/Time Initial Dose Given (DD/MM/YYYY):		Date/Time Next Dose Due (DD/MM/YYYY):			
# Days Remaining:		Limited Use Code:			
Site Care: <input type="checkbox"/> As per Best Practice Guidelines Canadian Vascular Access Association and Registered Nurses Association of Ontario <input type="checkbox"/> Other (Specify):					
Next dressing change due (DD/MM/YYYY):					
Flush Instructions: <input type="checkbox"/> Local Nursing Provider Protocol			<input type="checkbox"/> Other (Specify):		
For High Risk Medications Vancomycin/Aminoglycosides: <input type="checkbox"/> Lab Requisition Provided to Patient					
Date of Last Blood Work (DD/MM/YYYY):		Time (HH/MM):		Serum Creatinine Results:	
Trough Level:		Blood Urea Nitrogen Level:		Date of Next Blood Work Due (DD/MM/YYYY):	
Wound Care Orders: (Wound Care Pathways)					
<input type="checkbox"/> Initiate wound-specific clinical pathways					
<input type="checkbox"/> Wound Care as follows:					
<input type="checkbox"/> Negative Pressure Wound Therapy (NPWT)		Dressing Size: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> Extra Large			
Foam Type:		Cycle: <input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous Pressure Setting mmHG:			
In the event of NPWT failure, please provide back-up orders:					

As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

Additional Notes relating to the referral provided, see attached.

Health Care Practitioner Name

CPSO #

Signature/Designation

Date (DD/MM/YYYY)