Medical Referral Form Guidelines
For Adult Patients

Field	Content
Patient Demographics	**Place an Addressograph Label or at least two patient identifiers (i.e., patient first and last name and Health Card Number)**
Patient Name	Enter patient's surname and first name
Address	Enter street name and number of the house
City	Enter name of city or town
Postal Code	Enter postal code
Telephone	Enter patient's phone number where she/he can be reached
DOB (yyyy/mm/dd)	Enter patient's date of birth
HCN	Enter the patient's HCN
VER	Enter the patient's HCN version code if applicable
Alternate Contact & phone #	Enter an alternate contact name and phone number
Diagnosis; surgical procedure and date; reason for referral; other relevant diagnoses	• Enter diagnosis most relevant to the referral • Enter the surgical procedure or treatment and date • Enter other relevant medical hx
Communicable Diseases	• Answer yes or n/a; enter any communicable diseases if yes
Medication List:	• Check if list attached
Cumulative Patient Profile in Family Practice attached	• Check if profile is attached
Patient is homebound	• Check if patient is homebound
Allergies	• Enter all known allergies
Prognosis	• Note whether the patient's prognosis is less than 1 year OR greater than 1 year • Indicate 'yes' or 'no' as to if prognosis was discussed with patient/ family
Medication to be administered by Home and Community Care Support Services: Note: Same day medication orders must be received by Home and Community Care Support Services by 1300 hrs.	Include: drug, limited use code (if needed), dose, frequency and route of administration **Mandatory Fields:** • **Last dose given in Hospital: date and time** • **Next dose due in Community: date and time** • **Length of therapy to be given by Home and Community Care Support Services in days** • **Lab (result, monitor play & requisition)**
Best Practice Guidelines for IV Management will be followed unless specific orders are specified:	Best Practice Protocols (information only)
IV Route Access Device	Check IV appropriate Access Route box
New Central Line Tip Confirmed	• Check box that tip was confirmed at time of insertion in radiology • If documentation is available please send
Medication doses can be staggered to accommodate clinic hours	• Answer yes/no

Field	Content
Catheter re-insertion if patient unable to void following removal	• Answer yes/no
Service Requested	• Treatments will be taught and services reduced when appropriate
Nursing Wound Care	• Indicate wound • When appropriate indicate last ABPI measurement and date
Nursing – Other	• Enter all other nursing orders
Other Services Requested	Check appropriate service(s): • Telehomecare • Lab • Personal Support • Dietician • Social Work • Therapies
Degree of Weight Bearing	If ordering Physiotherapy indicate the patient's weight bearing status
Referring Physician/Nurse Practitioner	Print and sign first name, last name and include phone number, date and CPSO#
Alternate Most Responsible Physician / Nurse Practitioner	Print first name, last name and include phone number and date