

Tel: (705) 721-8010 Toll free 1-888-721-2222

Medical Referral

Fax: (705) 792-6270 Toll Free 1-866-700-1955

Diagnosis:				Patient Identification:				
Surgical Procedure/Date (if applicable):				Name (surname, first name):				
Reason for Referral:				Address:				
Other Relevant Medical Hx:				City:		Postal code:		
				Phone number:		DOB (yyyy/mm/dd):		
Communicable Diseases: n/a yes specify:				HCN:		VER:		
				Alternate contact:		Phone #:		
				*Mandatory if patient has cognitive impairment				
Medication List attached		Cumulative Patient Profile in Family Practice attached		Patient is homebound				
Allergies:								
Prognosis:		Less than 1 year		Greater than 1 year		Dx discussed with pt: yes no		
*Same day medication orders must be received by Ontario Health atHome by 1300hrs								
Medication to be administered by Ontario Health atHome	Limited Use(LU) Code	Dosage	Frequency	Route	Last Dose in Hospital: Date/Time	Next Dose in Community: Date/Time	Length of Therapy to be Given by HCCSS in Days	Lab (result, monitor plan & requisition)
Best Practice Guidelines for IV Management will be followed unless specific orders are specified IV Route Access Device: Peripheral CVAD IVAD - Type: _____ New Central Line Tip Confirmed Yes (Documentation attached) Yes No 1. Peripheral: 3mL N/S pre & post access; 2. Non-Valved CVAD & IVAD: 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant 3. Valved CVAD: Flush and lock with 10-20mL N/S after each access; weekly if dormant; 4. IVAD non-valved: 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; 5. IVAD Valved: flush and lock with 10-20mL saline Medication doses can be staggered to accommodate clinic hours Yes No Catheter re-insertion if patient unable to void following removal Yes No								
Service Requested		<i>Note: Treatments will be taught and services reduced when appropriate</i>						
Nursing - Wound Care*		NOTE: Wound care orders outside of best practice may not be eligible for Ontario Health atHome services. Wound care products may be substituted to a comparable product based on Ontario Health atHome supply list Wound Type: _____ Any specific instructions: _____						
*Ontario Health atHome has a clinic first approach; all nursing will be seen at a clinic unless patient is home bound and therefore unable to physically attend appointments outside of the home		Compression Therapy requires ABPI measurements				ABPI _____ Date: _____		
		YYYY/MM/DD						
Nursing – Other								
Please see above re clinic first approach								
Telehomecare (Must have diagnosis of COPD or CHF noted)								
Lab - Must attach Ministry of Health Lab requisition to this referral - for patients receiving in-home nursing/therapy				Personal Support (e.g., bathing, dressing, etc.)				
Dietician Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect)								
Therapies - must be necessary to enable the patient to remain in their home or enable them to return home.								
Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy)								
Degree of Weight Bearing: None Partial Full Progression								
Referring Physician/Nurse Practitioner Name (print): _____ Signature: _____ Phone: _____ CPSO # _____ Date: _____ YYYY/MM/DD				Alternate Most Responsible Physician/Nurse Practitioner Name (print): _____ Phone: _____				