

## Medical Referral

**Toronto Fax: (416) 222-6517    Newmarket Fax: (905) 952-2404**

**PATIENT DETAILS**
*(Patient Last Name, First Name)*

Home Address: \_\_\_\_\_ DOB (dd-mmm-yyyy): \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
 Health Card Number & Version Code: \_\_\_\_\_ Caseload: \_\_\_\_\_

DIAGNOSIS: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Surgical Procedure/Treatment: \_\_\_\_\_ Date: \_\_\_\_\_  
(dd-mmm-yyyy)

Other Significant Medical Information:

Allergies:  No  Unknown  Yes, Specify: \_\_\_\_\_

Multi-drug Resistant Organism (MRO):  No  Unknown  Yes, Specify: \_\_\_\_\_

<b>Diagnosis Discussed</b> With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Prognosis:</b> <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Unknown	<b>Prognosis Discussed</b> With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>DNR Order in Place</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
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The Patient/SDM is aware of the prognosis and should death occur, Physician or Nurse Practitioner (NP) \_\_\_\_\_  
 has agreed to make a home visit and sign a death certificate or, will arrange for a Physician substitute in  
 his/her absence -  No  Yes  
 Palliative Performance Score (PPS): \_\_\_\_\_ Edmonton Symptom Assessment Scale (ESAS): \_\_\_\_\_

### MEDICAL ORDERS

#### TREATMENT ORDERS

**Weight Bearing (WB)**  
 (\*\*Mandatory for patients requiring therapy services)

	<b>R</b>	<b>L</b>		<b>R</b>	<b>L</b>
Full	<input type="checkbox"/>	<input type="checkbox"/>	Feather	<input type="checkbox"/>	<input type="checkbox"/>
Partial	<input type="checkbox"/>	<input type="checkbox"/>	Non-WB	<input type="checkbox"/>	<input type="checkbox"/>

#### INFUSION ORDER (\*\*Mandatory Information)

**Initial Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
(dd-mmm-yyyy)

**Next Dose in Home:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
(dd-mmm-yyyy)

**Central Venous Lines:**  
 Valved:  No  Yes      Tip Confirmed:  No  Yes

**Flushing Protocols:**

**Clinic/Follow-up Appointment:** \_\_\_\_\_  
(dd-mmm-yyyy)

**Lab Tests:** Type, Frequency: \_\_\_\_\_  
 Results To: \_\_\_\_\_

Phone #: \_\_\_\_\_ Start Date: \_\_\_\_\_  
(dd-mmm-yyyy)

**Diabetic:**  No  Yes      **Beta Blockers:**  No  Yes

Phone Order From Physician/NP: \_\_\_\_\_ To: \_\_\_\_\_ Date: \_\_\_\_\_  
(dd-mmm-yyyy)

**SIGNATURE OF PHYSICIAN/NP:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(dd-mmm-yyyy)

Care Coordinator: \_\_\_\_\_  
 Phone # and Extension: \_\_\_\_\_ Date: \_\_\_\_\_  
(dd-mmm-yyyy)

## Medical Referral

### CONTROLLED ACTS ARE AS FOLLOWS:

- Performing a prescribed procedure below the dermis or a mucous membrane
- Administering a substance by injection or inhalation
- Putting an instrument, hand or finger:
  1. beyond the external ear canal
  2. beyond the point in the nasal passages where they normally narrow
  3. beyond the larynx
  4. beyond the opening of the urethra
  5. beyond the labia majora
  6. beyond the anal verge
  7. into an artificial opening into the body
- Dispensing