HOME AND COMMUNITY CARE SUPPORT SERVICES
Central West

MEDICAL REFERRAL
Fax: 905-796-4671
Phone: 905-796-0040
Toll Free: 1-888-733-1177

Addressograph or Label

Confirmed Discharge Date: _____ or within: ☐ 24 hrs ☐ 48 hrs ☐ 72 hrs ☐ Other

Diagnosis:	**Allergies:**	**Precautions:** ☐Contact ☐Droplet/Contact ☐Droplet ☐Airborne **Reason for isolation:**

Prognosis (i.e. Months): _____ **Discussed Care Plan with Patient/Caregiver** ☐ Yes ☐ No
Discussed Care Plan with Primary Care Provider ☐ Yes ☐ No ☐ N/A

Palliative Performance Scale (0-100%):_____% ☐ Improve ☐ Remain Stable ☐ Maintenance ☐ Deteriorate

Service Requested — *Note: Eligible patients will receive nursing services within a clinic setting*

Nursing: Wound Care
As per Integrated Wound Care Pathways

☐ Pilonidal Sinus	☐ Diabetic Foot Ulcer	☐ Pressure Injury (Stage_____)	☐ Maintenance/Chronic Arterial Ulcer	
☐ Venous Leg Ulcer	☐ Surgical Acute	☐ Lymphedema	☐ Non-Complex Burn	☐ Skin Tear
☐ Cellulitis	☐ Surgical Chronic	☐ Trauma	☐ Other: _____	

Compression Therapy for VLU – requires recent measurements: (ABPI)_____ Date: _____

NOTE: Wound care products may be substituted with a comparable product based on Home and Community Care Support Services Central West supply list.

Other – refer to 'Additional Orders'

☐ **Nursing: Specialty**	☐ Rapid Response Nurse ☐ NP-Palliative – Reason for Referral to NP: _____
☐ **Nursing: General**	☐ Ostomy Care/teaching ☐ Drain Care/Teaching ☐ Catheter Care/Teaching ☐ Enteral Feed ☐ Palliative Care ☐ Symptom Management ☐ Other: _____

ADDITIONAL ORDERS *(attach additional information as needed):*

☐ **Nursing: IV Medication #1**	**Drug** _____	**Dose** _____	**Route** _____	**Frequency** _____
	Duration _____	**First dose given in hospital?** ☐ **Yes** ☐ **No**	***Time of administered last dose:** _____	
☐ **Nursing: IV Medication #2**	**Drug** _____	**Dose** _____	**Route** _____	**Frequency** _____
	Duration _____	**First dose given in hospital?** ☐ **Yes** ☐ **No**	***Time of administered last dose:** _____	
☐ **Nursing: IV Hydration**	Solution:_____ Rate:_____ Duration:_____ Start: _____			
☐ **Nursing: Central Lines (Adults)**	☐ **PICC line flush orders:** Flush and lock each lumen with 10 mL NaCl 0.9% post infusion, weekly and PRN. **Insertion Date:** _____ ☐ **Central venous line dressing orders:** Cleanse site with chlorhexidine and apply op-site weekly and PRN, change cap weekly. ☐ **Port-a-Cath care orders:** Flush and lock port-a-cath with 10 mL NaCl 0.9%. Flush q 1 month when not in use using a non-coring needle. ☐ **Tunneled catheter (e.g. Hickman) flush orders:** Flush and lock each lumen with 10 mL NaCl 0.9% weekly.			

☐ **Additional Recommendations (e.g. OT, PT, Pharmacy Consult, etc.)** **Weight bearing status:**

***Note:** Eligibility and availability to be assessed and determined by a Home and Community Care Support Services Central West Care Coordinator **(attach additional information as needed).**

Patient has been informed to follow up with their Primary Care Provider: ☐ **Yes, within** _____ **days** ☐ **No** ☐ **N/A**
Hospital to Home (H2H): Patient will be **enrolled into the H2H Program if they meet the inclusion criteria**

Referring Physician/Nurse Practitioner/Other	**OHIP Billing #**	___/___/___
Name (Print):_____ **Signature:** _____ **Designation:**_____ **Telephone**: (_____) _____-_____		DD/MM/YY

Ontario