Ontario Health atHome

REFERRAL FOR SERVICES

Fax to:

Kirkland Lake	North Bay	Parry Sound	Sault Ste. Marie	Sudbury	Timmins
705 567 9407	705 474 0080	1 855 773 4056	705 949 1663	705 522 3855	705 267 7795

☐ **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: ☐ English ☐ French ☐ Other (specify):		
Gender: ☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown	Weight (kg):	Height (cm):	
Name of Contact Person (if other than Patient):			
Phone #:	Relationship: ☐ POA/SDM ☐ Spouse ☐ Other (specify):		
Relevant diagnosis:	Reason for Referral:		
Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate	Planned Hospital Discharge Date (DD/MM/YYYY):		
Location and Type of wound (if any):			
Infection control: ☐ MRSA Positive ☐ VRE Positive ☐ C-diff ☐ TB ☐ Other (Specify):			
Surgical Procedure:	Surgical Date (DD/MM/YYYY):		
Weight bearing status: ☐ Full-weight ☐ Non ☐ Partial	Activity/Mobility Restrictions:		

SERVICES REQUESTED

☐ Nursing	☐ Enterostomal Therapist/NSWOC
☐ Personal Support	☐ Rapid Response Nursing (Sudbury, Manitoulin, Espanola, North Bay, Sault Ste. Marie, Timmins, Parry Sound)
☐ Occupational Therapy	☐ Telehomecare Nursing
☐ Physiotherapy	☐ Social Work
☐ Dietetics	☐ Speech-Language Pathology

☐ NP Primary Care (Sudbury, North Bay, Sault Ste. Marie) ☐ NP Palliative Care (Sudbury, Manitoulin, West Nipissing, Kirkland Lake, Sault Ste. Marie, Timmins)

☐ 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: ☐ Subcutaneous ☐ Peripheral IV ☐ 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: ☐ Subcutaneous ☐ Peripheral IV ☐ 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: ☐ As per Best Practice Guidelines Canadian Vascular Access Association and Registered Nurses Association of Ontario
☐ Other (Specify): Next dressing change due (DD/MM/YYYY):

Flush Instructions: ☐ Local Nursing Provider Protocol ☐ Other (Specify):

For High Risk Medications Vancomycin/Aminoglycosides: ☐ 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:

☐ Initiate wound-specific clinical pathways
☐ Wound Care as follows**:**
☐ Negative Pressure Wound Therapy (NPWT) Dressing Size: ☐ Small ☐ Medium ☐ Large ☐ Extra Large
Foam Type: Cycle: ☐ Intermittent ☐ 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)