CLEAR

Ontario Health atHome
North Simcoe Muskoka

Medical Referral

Tel: (705) 721-8010 Toll free 1-888-721-2222 **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: ***Mandatory if patient has cognitive impairment**	Phone #:

☐ 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

Service Requested	*Note: Treatments will be taught and services reduced when appropriate*
☐ Nursing - Wound Care* ***NSM 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**	*NOTE: Wound care orders outside of best practice may not be eligible for Home and Community Care Support Services. Wound care products may be substituted to a comparable product based on Home and Community Care Support Services supply list* Wound Type: _____ **Any specific instructions:** Compression Therapy requires ABPI measurements ABPI Date:
☐ Nursing – Urinary Catheter Care ***Please see above re clinic first approach***	Catheter Size ☐ 14Fr ☐ 16Fr ☐ other_____ Change Frequency: ☐ q4weeks/PRN ☐ other _____ **NS Flushing**: ☐ 60mL-120mL ☐ other_____ ☐ PRN ☐ other_____ **Trial of Void** Date: _____ Timeframe: ☐ 4-8hrs ☐ other____ Repeat TOV: ☐ weekly x____week(s) Size of catheter for reinsertion: ☐ 14Fr ☐ 16Fr ☐ other_____ Referred Urologist: _____ **Clean Intermittent Catheterization**: Start Date: _____ Frequency: _____Catheter Size/Type_____
☐ 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.)

Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect)

Therapies - Eligible if unable to access outpatient / community-based care

Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy, Dietician)	

Degree of Weight Bearing: ☐ None ☐ Partial ☐ Full ☐ Progression

Referring Physician/Nurse Practitioner	**Alternate Most Responsible Physician/Nurse Practitioner**
Name (print)**:** _____	**Name** (print)**:** _____
Signature: _____	**Phone:** _____
Phone: _____ CPSO #_____ Date: _____	**Extension:** _____
Extension: _____	