HOME AND COMMUNITY CARE SUPPORT SERVICES ERIE ST. CLAIR
SERVICES DE SOUTIEN A DOMICILE ET EN MILIEU COMMUNAUTAIRE D'ÉRIÉ ST-CLAIR

Print

Referral and Treatment Plan - Pain Medication Order

☐ Chatham Head Office
Ph: 1-888-447-4468
Fax: 519-351-5842

☐ Sarnia Branch
Ph: 1-888-447-4468
Fax: 519-337-4331

☐ Windsor Branch
Ph: 1-888-447-4468
Fax: 519-258-6288

Community: _____

Hospital: _____ Unit: _____

Alternative Contact for Patient: _____

Relationship: _____ Phone: _____

Patient Demographics

Patient Name: _____

☐ M ☐ F DOB: _____ (dd/mm/yy)

HCN: _____ VC: _____

Address/911: _____

City: _____ PC: _____

Phone: _____

☐ **Patient Agrees to Referral**

Service Needed: (Assessment by HCCSS ESC to determine services in clinic or home)

☐ Nursing ☐ Palliative (PCCT) ☐ Personal Support ☐ Telemedicine ☐ Long Term Care Placement

☐ Dietician ☐ Social Work ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Language Pathology

☐ COPD Teams

Reason for Referral: _____

Diagnosis: _____

☐ NKA ☐ Allergies/Sensitivities: _____

Medical Orders

Best practice/evidenced based practice will be initiated unless otherwise written. Wound care outside of evidenced based practice may not be eligible for HCCSS services. Treatment will be taught and service reduced when appropriate.

Specify Wound: ☐ Surgical ☐ Malignant ☐ Pilonidal ☐ Traumatic ☐ Venous Leg Ulcer ☐ Arterial Leg Ulcer
☐ Diabetic Foot Ulcer ☐ Maintenance ☐ Non-Healing ☐ Other: _____
☐ Pressure Ulcer: **Specify Stage:** ☐ 1 ☐ 2 ☐ 3 ☐ 4

IV Therapy: ☐ Peripheral ☐ PICC - Catheter Length: Internal: _____ cm External: _____ cm
☐ Subcutaneous ☐ Central Number of Lumens: ☐ 1 ☐ 2 ☐ 3
First Dose Given: ☐ Yes ☐ No **Date and Time Next Dose Due:** _____

Pain Medication Order for Infusion Pump

Drug: _____

Total Cassette/Bag Volume: _____ Final Concentration: _____ ☐ mg/ml ☐ mcg/ml

Basal Rate: _____ ☐ mg/hr ☐ mcg/hr

Bolus Dose: _____ ☐ mg ☐ mcg every _____ minutes

Bolus Dose Max: _____ per hour

Total Number of Cassettes: _____ Dispense: _____ every _____ days

Additional Referral Information /Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

Signature	Print Name/Designation/Title	OHIP Billing Code [1]
CPSO/CNO Reg. Number	Phone Number	Date (dd/mm/yy)

[1] Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.