HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Hamilton Niagara Haldimand Brant

Long-Term Care Home Referral for Services

To accompany ALL requests for Nursing, Wound Care Specialist or Speech Language Pathologist for Swallowing Assessment

Contact HCCSS HNHB at **1-800-810-0000** Fax: 905-639-8704 or 1-866-655-6402

Patient Name _____ **HCN** _____ **VC** _____ **DOB** _____

Facility and Address _____ **City** _____

Ward _____ **Room** _____ **Facility Phone** _____

Service Required

☐ Nursing for IV - Medical Orders for IV must accompany this referral

☐ Wound Care Specialist - Section below must be completed

☐ Speech Language Pathologist for Swallowing Assessment - Section below must be completed

Diagnosis/Medical History

Cognitive Status ☐ Intact ☐ Disoriented Disoriented to: ☐ Time ☐ Person ☐ Place ☐ Forgetful

Behavioural Status ☐ Cooperative ☐ Agitated ☐ Aggressive ☐ Resistive to Treatment

Allergies ☐ Yes ☐ No **Describe**: _____

Infectious Precautions ☐ Routine ☐ Contact ☐ Airborne

LONG-TERM CARE FACILITY

Facility Contact Person _____
Name *EXT*

Resident Contact Person _____ **Phone** _____

Relationship _____

Referral Requested By ☐ Physician ☐ Staff ☐ Family ☐ Resident ☐ Urgent ☐ Non-Urgent ☐ Other

Consent received for referral/assessment? ☐ Yes ☐ No

Consent received for collection, use and disclosure of health information with providers necessary to provide intervention? ☐ Yes ☐ No

Consent received from ☐ Client ☐ Substitute Decision Maker (if client not capable)

If Consent provided by SDM _____ _____
Name & Relationship to Client *Phone*

Form Completed By _____ _____ _____ _____
Signature *Title* *Print Name* *Date*

Wound Consult Nurse Assessment

Location of Wound(s) _____

Wound Measurements (LxWxD) _____

Dressing Treatment/Frequency _____

Reason for Wound Consult Nurse Assessment

Print Clear

Ontario

Version **23-001**

Patient Name _____ **HCN** _____

Speech Language Pathologist for Swallowing Assessment

Signs and Symptoms

Frequent coughing while eating and/or drinking ☐ Yes ☐ No
If yes, on what foods?_____
Frequency of choking/coughing ☐ Every Day ☐ 1x/week Other: _____
Is this a long-standing problem? ☐ Yes ☐ No
If no, how recent?_____
Other feeding/swallowing problems: _____
Is the problem related to feeding the client? ☐ Yes ☐ No Type of diet? _____
Is the problem related to positioning the client? ☐ Yes ☐ No Type of diet? _____
Is the client a self-feeder? ☐ Yes ☐ No
Aspiration Pneumonia? ☐ Yes ☐ No If yes, when? _____
Recent Chest X-Ray? ☐ Yes ☐ No
If yes, when? Results? _____
Any Changes in Medication? ☐ Yes ☐ No
Weight Loss? ☐ Yes ☐ No How much? _____
Any previous swallowing assessment in past year? ☐ Yes ☐ No
Provided by whom? _____
Any strategies attempted? (e.g.Thick-it, position, etc.) ☐ Yes ☐ No
Have the strategies helped? ☐ Yes ☐ No

What is the purpose of this assessment?

Completed By: NAME _____ **SIGNATURE** _____

Phone _____ **Date** _____

General Comments

Staff Completing Referral

Referring Practitioner Name (print)_____ CPSO/CNO# if applicable _____
Practitioner Address and Phone _____
Phone and Extension _____ Preferred Contact Number _____
Signature _____ Date _____ Time _____