HOME AND COMMUNITY CARE SUPPORT SERVICES
Mississauga Halton

2655 North Sheridan Way, Suite 140
Mississauga, ON L6Y 0P2
Tel: 905-855-9090 / 1-877-336-9090
Fax: 905-855-8989 / 1-877-298-8989
***Hospital in-patient: Use Hospital HCCSS Office fax number**

REFERRAL FORM

Anyone can make a referral to Home and Community Care Support Services. Physician signature only required for nursing services. If Physician orders weightbearing, ROM or Functional Restrictions, please include all details below. Note: To ensure patient safety and care continuity, please complete this Referral Form in full. Palliative referrals are to use the Palliative Care Services Referral Form available **at healthcareathome.ca**

When completing Referral:

1. Identify reason/need for each service selected
2. Provide Treatment Orders and Start Date, as applicable
3. Nursing Service: All patients who meet our nursing services eligibility criteria will receive care in a community **nursing clinic**. In home nursing will be considered by **exception only**

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME**: _____

HCN #: _____ **VC**: _____ **DATE OF BIRTH**: _____

ADDRESS: _____ **APT#**: _____

CITY: _____ **PROVINCE**: _____ **POSTAL CODE**: _____

TELEPHONE #: _____ **ALTERNATE #:** _____

PREFERRED LANGUAGE: _____ **Interpreter/Communication Aid Required:** _____

PRIMARY CONTACT INFORMATION

LAST NAME: _____ **FIRST NAME**: _____

TELEPHONE #: _____ **ALTERNATE #:** _____

PREFERRED LANGUAGE: _____ **Interpreter/Communication Aid Required:** _____

Is the Patient/POA/SDM aware of this referral? ☐ Yes ☐ No

☐ Community Referral ☐ Hospital Referral Planned date of Discharge: _____

MEDICAL INFORMATION

PRIMARY DIAGNOSIS:

ALLERGIES:

RELEVANT MEDICAL HISTORY/IPAC:

MOBILITY: Ambulatory: ☐ Yes ☐ No **Patient Uses**: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter ☐ Homebound

OTHER CONCERNS: ☐ Lives Alone ☐ Limited Social Network ☐ Finances ☐ Transportation ☐ Housing ☐ Hearing Loss ☐ Vision Loss

PRIMARY CARE PRACTITIONER INFORMATION (if different from Referral Source)

NAME: _____ **TELEPHONE #**: _____ **FAX #**: _____ **CPSO #**: _____

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE RECEIVED THIS FORM IN ERROR, PLEASE DO NOT COPY OR DISPOSE OF. CONTACT 905-855-9090 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT

Ontario

REFERRAL FORM

LAST NAME: _____ **FIRST NAME**: _____

HCN #: _____ **VC**: _____

☐ **Nursing: Wound Care**

Wound Location: _____ **Wound Dimensions**: _____ **Wound Description**: _____

☐ Pilonidal Sinus ☐ Diabetic Foot Ulcer ☐ Pressure Injury **Stage**: _____ ☐ Arterial Leg Ulcer ☐ Venous Leg Ulcer

☐ Lymphedema ☐ Surgical ☐ Cellulitis ☐ Traumatic ☐ Other: _____

☐ **Nursing: Medication**

Name of Medication: _____ **Dose**: _____ **Frequency**: _____

Duration: _____ **Route**: _____ ☐ PICC ☐ Port-A-Cath ☐ Peripheral IV

Date and Time of last dose given: _____ **Patient advised to return to ED for doses?** ☐ Yes ☐ No

Screening for 1st dose administration in the community:

1. History of serious adverse or allergic reaction to the prescribed medication or related compound? ☐ Yes ☐ No
2. Patient currently on beta-blockers? ☐ Yes ☐ No

If NO to both above – OK to administer 1st dose in the community? ☐ Yes ☐ No

☐ **IV Access Route Care**

Last Flush Date:

_____

Last Dressing Change Date:

_____

☐ **Peripheral**: Flush 2-3 cc 0.9% NS OD

☐ **Valved PICC:** Flush 0.9% NS 10 ml
Frequency: Flush after each access or weekly if not in use **Dressing & Cap Change**: Q weekly PRN

☐ **Non-valved PICC**: Flush 0.9% NS 10 ml followed by 300 units of Heparin
Frequency: Flush after each access or weekly if not in use **Dressing & Cap Change**: Q weekly PRN

☐ **Port-a-Cath:** Flush 0.9% NS 10 – 20/ml followed by 500 units of Heparin **Frequency**: ☐ Monthly ☐ Q3 months
Remove gripper with chemo disconnect **Gripper size**: _____

☐ **Additional Orders:** _____
(e.g. Hickman, Apheresis, Midline, additional Heparin Orders) ☐ See attached protocol

COVID19 Therapeutics Date of Symptom onset: _____

☐ Patient qualifies for Remdesivir treatment as per Ontario Health guidelines (if not, an alternate treatment will need to be sourced)

☐ Remdesivir 200 mg IV on Day 1m 100 mg IV daily on days 2 and 3

Is patient on beta-blockers? ☐ Yes ☐ No If yes, does the benefit of Remdesivir treatment outweigh risk? ☐ Yes ☐ No

☐ **Drain Care:** _____ ☐ Stoma Care

☐ **Urinary Catheter Care** **Change Indwelling Catheter**: ☐ Monthly ☐ Q3 months ☐ Other: _____

☐ Irrigation Solution: _____ Amount: _____ cc until clear

☐ Removal Date: _____ ☐ Trial of void – reinsert if unable to void Size: _____

☐ Physiotherapy
☐ Occupational Therapy

Weightbearing status: ☐ Non-weightbearing ☐ Toe Touch ☐ Partial ☐ WB as Tolerated ☐ Full

ROM Limitations: _____

Functional/Lifting Restrictions: _____

☐ Speech Language Pathology ☐ Registered Dietician ☐ Social Work ☐ Rapid Response Nurse

☐ Personal Support (e.g. bathing, dressing) ☐ Caregiver Respite ☐ Navigation to Community Supports ☐ Respiratory Therapy

☐ Long-term Care ☐ Short Stay Respite ☐ Convalescent/Restore ☐ Adult Day Program ☐ General Assessment

Additional Information:

REFERRAL SOURCE

NAME (please print): _____ ☐ MD ☐ RN (EC)

TELEPHONE #: _____ **FAX #**: _____

SIGNATURE: _____ **DATE**: _____ **CPSO/CNO #**: _____