HOME AND COMMUNITY CARE SUPPORT SERVICES
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

***Same day medication orders must be received by Home and Community Care Support Service by 1300hrs**

Medication to be administered by Home and Community Care Support Services	Limited Use(LU) Code	Dosage	Frequency	Route	Last Dose in Hospital: Date/Time	Next Dose in Community: Date/Time	Length of Therapy to be Given by HCCSS in Days	Lab (result, monitor plan & requisition)

Best Practice Guidelines for IV Management will be followed unless specific orders are specified

IV Route Access Device: ☐ Peripheral ☐ CVAD ☐ IVAD - Type**:**

New Central Line Tip Confirmed ☐ **Yes (Documentation attached)** ☐ **Yes** ☐ **No**

1. Peripheral: 3mL N/S pre & post access; **2. Non-Valved CVAD & IVAD:** 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant **3. Valved CVAD:** Flush and lock with 10-20mL N/S after each access; weekly if dormant; **4. IVAD non-valved**: 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; **5. IVAD Valved**: flush and lock with 10-20mL saline

Medication doses can be staggered to accommodate clinic hours ☐ Yes ☐ No

Catheter re-insertion if patient unable to void following removal ☐ Yes ☐ No

Remdesivir

History of serious adverse or allergic reaction to the prescribed medication or related compound? ☐ Yes ☐ No

Patient currently on beta-blockers, A.C.E. Inhibitors and anti-adrenergic drugs? ☐ Yes ☐ No

If no to both questions – OK to administer 1st dose in home? ☐ 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: ________ YYYY/MM/DD
☐ Nursing – Other ***Please see above re clinic first approach***	

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<table>
<tr><td colspan="2">☐ TeleHomecare (Must have diagnosis of COPD or CHF noted)</td></tr>
<tr><td>☐ Lab - Must attach Ministry of Health Lab requisition to this referral - for patients receiving in-home nursing/therapy</td><td>☐ Personal Support (e.g., bathing, dressing, etc.)</td></tr>
<tr><td colspan="2">☐ Dietician ☐ Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect)</td></tr>
<tr><td colspan="2">Therapies - must be necessary to enable the patient to remain in their home or enable them to return home.</td></tr>
<tr><td>Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy)</td><td></td></tr>
<tr><td colspan="2">Degree of Weight Bearing: ☐ None ☐ Partial ☐ Full ☐ Progression</td></tr>
<tr><td>Referring Physician/Nurse Practitioner
Name (print): ________________________________
Phone: (____) (____)-(______) CPSO #_________ Date: _____________
YYYY/MM/DD
Signature: ___________________________________</td><td>Alternate Most Responsible Physician/Nurse Practitioner
Name (print): _________________________________
Phone: (____) (____)-(______)</td></tr>
</table>

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