Ontario Health atHome

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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 Ontario Health atHome Office fax number**

# REFERRAL FORM

***Anyone can make a referral to Ontario Health atHome. 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 www.ontariohealthathome.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***

# 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 Science Table 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

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

**Additional Information**:

X Remote Care Management: ☐ COVID-19 ☐ COPD ☐ CHF ☐ Other: _____

Standard parameters unless otherwise indicated

| ☐ Default | Systolic BP | Diastolic BP | O2 Saturation | Pulse | Weight (lbs.) *CHF only |
|---|---|---|---|---|---|
| High | 150 | 100 | 100 | 100 | +2 lbs./ DAY |
| Low | 90 | 60 | 92 (*88 COPD) | 50 | -5 lbs./ DAY |

## REFERRAL SOURCE

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

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

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