

<b>Diagnosis:</b>				<b>Patient Identification:</b>				
<b>Surgical Procedure/Date</b> (if applicable):				Name (surname, first name):				
<b>Reason for Referral:</b>				Address:				
Other Relevant Medical Hx:				City:		Postal code:		
				Phone number:		DOB (yyyy/mm/dd):		
Communicable Diseases: <input type="radio"/> n/a <input type="radio"/> yes specify:				HCN:		VER:		
				Alternate contact:		Phone #:		
				<b>*Mandatory if patient has cognitive impairment</b>				
<input type="checkbox"/> Medication List attached				<input type="checkbox"/> Cumulative Patient Profile in Family Practice attached				
				<input type="checkbox"/> Patient is homebound				
<b>Allergies:</b>								
<b>Prognosis:</b> <input type="radio"/> Less than 1 year <input type="radio"/> Greater than 1 year				Dx discussed with pt: <input type="radio"/> yes <input type="radio"/> no				
<b>*Same day medication orders must be received by Ontario Health atHome by 1300hrs</b>								
Medication to be administered by Ontario Health atHome	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)
<b>Best Practice Guidelines for IV Management will be followed unless specific orders are specified</b> IV Route Access Device: <input type="checkbox"/> Peripheral <input type="checkbox"/> CVAD <input type="checkbox"/> IVAD - Type: _____ <b>New Central Line Tip Confirmed</b> <input type="radio"/> Yes (Documentation attached) <input type="radio"/> Yes <input type="radio"/> No <b>1. Peripheral:</b> 3mL N/S pre & post access; <b>2. Non-Valved CVAD &amp; IVAD:</b> 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant <b>3. Valved CVAD:</b> Flush and lock with 10-20mL N/S after each access; weekly if dormant; <b>4. IVAD non-valved:</b> 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; <b>5. IVAD Valved:</b> flush and lock with 10-20mL saline <b>Medication doses can be staggered to accommodate clinic hours</b> <input type="radio"/> Yes <input type="radio"/> No <b>Catheter re-insertion if patient unable to void following removal</b> <input type="radio"/> Yes <input type="radio"/> No								
<b>Service Requested</b>		<i>Note: Treatments will be taught and services reduced when appropriate</i>						
<input type="checkbox"/> Nursing - Wound Care*		NOTE: Wound care orders outside of best practice may not be eligible for Ontario Health atHome services. Wound care products may be substituted to a comparable product based on Ontario Health atHome supply list Wound Type: _____ <b>Any specific instructions:</b> _____						
<input type="checkbox"/> Nursing – Other <b>*Please see above re clinic first approach*</b>		Compression Therapy requires ABPI measurements				ABPI _____ Date: _____		
		YYYY/MM/DD						
<input type="checkbox"/> Telehomecare (Must have diagnosis of COPD or CHF noted)								
<input type="checkbox"/> Lab - Must attach Ministry of Health Lab requisition to this referral - for patients receiving in-home nursing/therapy				<input type="checkbox"/> Personal Support (e.g., bathing, dressing, etc.)				
<input type="checkbox"/> Dietician		<input type="checkbox"/> Social Work (catastrophic situation/crisis/lack of necessity/abuse/neglect)						
<b>Therapies - must be necessary to enable the patient to remain in their home or enable them to return home.</b>								
Specify Therapy requested (Occupational Therapy, Physiotherapy, Speech Therapy)								
Degree of Weight Bearing: <input type="radio"/> None <input type="radio"/> Partial <input type="radio"/> Full <input type="radio"/> Progression								
<b>Referring Physician/Nurse Practitioner</b>				<b>Alternate Most Responsible Physician/Nurse Practitioner</b>				
Name (print): _____				Name (print): _____				
Signature: _____				Phone: _____				
Phone: _____ CPSO # _____ Date: _____				YYYY/MM/DD				

**Clear Form**