

## **Patient Demographics Referral and Treatment Plan** Patient Name: ☐ Windsor Site $\square M$ $\square F$ ☐ Chatham Site ☐ Sarnia Site DOB:\_\_\_\_ Ph: 1-888-447-4468 Ph: 1-888-447-4468 Ph: 1-888-447-4468 (dd/mm/yy) Fax:1-844-858-3546 HCN: \_\_\_\_\_\_VC:\_\_\_\_ Fax:1-844-858-3546 Fax:1-844-858-3546 Address/911: Community: City: PC: \_\_\_\_\_Unit:\_\_\_ Hospital: Alternative Contact for Patient: Phone: Relationship: Phone: \_\_\_\_\_ ☐ Patient Agrees to Referral Service Needed: (Assessment by Ontario Health atHome to determine services in clinic or home) □ Nursing □ Palliative Care □ PSW □ Telehomecare □ Long Term Care □ Dietician □ Social Work □ PT □ OT □SLP ☐ Behavioural Support Ontario (BSO) Reason for Referral: Diagnosis: □Allergies/Sensitivities: $\square$ NKA **Medical Orders** Best practice/evidenced based practice will be initiated unless otherwise written. Wound care outside of evidenced based practice may not be eligible for Ontario Health atHome services. Treatment will be taught and service reduced when appropriate. Specify Wound: □Surgical □Malignant □Pilonidal □Traumatic □Venous Leg Ulcer □Arterial Leg Ulcer □ Diabetic Foot Ulcer □ Maintenance □ Non-Healing □ Other: \_\_\_\_\_ Pressure injury: Stage: □1 □2 □3 □4 IV Therapy: Peripheral PICC Midline – Catheter Length: Internal: cm External: cm □ Subcutaneous □ Central Number of Lumens: □1 □2 □3 Drug: **Dose:** \_\_\_\_\_Frequency: ☐ q24h ☐ q12h ☐ q8h ☐ q6h ☐ q4h Other:\_\_\_\_\_ Duration of remaining community treatment: \_\_\_\_\_Days (number of) or \_\_\_\_\_\_ Doses (number of) Last Dose in Hospital: Date: (dd/mm/yy)\_\_\_\_\_\_ Time:\_\_\_\_ □ am □ pm □ N/A Community Therapy to Start: Date: (dd/mm/yy) Time: □am □ pm ☐ Has received same medication and route within past 12 months ☐ Has NOT received medication within past 12 months - First Dose Parenteral Screener Completed □ REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines Start time may be delayed up to 8 hours if the next dose due is between midnight to 0800h.

Additional Referral Information/ Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

Signature	Print Name/Designation/Title	OHIP Billing Code 1
CPSO/CNO Peg. Number	Dhone Number	Date (dd/mm/w/)