Ontario Health atHome

**REFERRAL FOR CENTRAL VENOUS ACCESS DEVICE (CVAD) THROUGH REGIONAL CANCER PROGRAM**

| **DEMOGRAPHICS** | | | |
|---|---|---|---|
| Health Card Number: | Version Code: | Date of Birth (DD/MM/YYYY): | |
| Surname: | First name(s): | | |
| Address: | City: | Province: | Postal Code: |
| Phone #: | Primary language: ☐ English ☐ French ☐ Other (specify): | | |
| Gender: ☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown | | Weight (kg): | Height (cm): |
| Name of Contact Person (if other than Patient): | | | |
| Phone #: | Relationship: ☐ POA/SDM ☐ Spouse ☐ Other (specify): | | |
| **HEALTH STATUS** | | | |
| Relevant diagnosis: | | | |
| Infection control: ☐ MRSA Positive ☐ VRE Positive ☐ C diff ☐ TB ☐ Other (Specify): | | | |
| Type of CVAD: ☐ PICC ☐ HICKMAN ☐ PORTACATH ☐ Other (specify): | | | |
| Weight bearing status: ☐ Full-weight ☐ Non ☐ Partial (specify restrictions): | | | |
| **CVAD CARE NEEDS** | | | |
| ☐ CVAD Dressing change<br>☐ Flush with 20 mL Sterile Sodium Chloride 0.9% weekly and PRN<br>☐ Other (specify):<br>Requested/Specific schedule for PICC line care: | | | |
| **CONSENT (MANDATORY)** | | | |
| Consent for referral provided by: ☐ Patient ☐ SDM | | | |
| Is patient aware of referral? Yes ☐ ☐ No | | | |
| Type of consent obtained: ☐ Verbal ☐ Written Date obtained (DD/MM/YYYY): | | | |
| Is patient aware that all CVAD care is done at an outpatient clinic? Yes ☐ ☐ No | | | |
| Has CVAD line teaching been done by the Regional Cancer Program nurse? ☐ Yes ☐ No | | | |
| Has patient been instructed to carry their PICC ID/Maintenance Card ***and*** the CVAD tip confirmation report with them, at time of clinic appointments? ☐ Yes ☐ No | | | |

*Important Note: If the patient requires any additional services beyond outpatient nursing for CVAD care, the standard 'Referral for Services' form should be used.*

☐ Additional Notes relating to the referral have been provided, see attached.

Printed Name _____ Signature/Designation _____ Date (DD/MM/YYYY) _____

| ☐ KIRKLAND LAKE | ☐ NORTH BAY | ☐ PARRY SOUND | ☐ SAULT STE. MARIE | ☐ SUDBURY | ☐ TIMMINS |
|---|---|---|---|---|---|
| Fax : 705 567 9407 | Fax: 705 474 0080 | Fax: 1 855 773 4056 | Fax: 705 949 1663 | Fax: 705 522 3855 | Fax: 705 267 7795 |