

WRH-MC OP

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| | Patient Demographics | |
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| Referral and Treatment Plan | Patient Name: | |
| □ Chatham Site □ Sarnia Site □ Windsor Site Ph: 1-888-447-4468 Ph: 1-888-447-4468 Ph: 1-888-447-4468 Fax:1-844-858-3546 Fax:1-844-858-3546 Fax:1-844-858-3546 | (dd/iiiii/yy/ | |
| Community: | Address/911: | |
| Hospital:Unit: | City:PC: | |
| Alternative Contact for Patient: | Phone: | |
| Relationship:Phone: | | |
| □ Patient Agrees to Referral Service Needed: (Assessment by Ontario Health atHome to determine | • | |
| □ Nursing | e □Dietician □Social Work □ PT □OT | |
| □ Behavioural Support Ontario (BSO) Reason for Referral: | | |
| Diagnosis: | | |
| □ NKA □ Allergies/Sensitivities: | | |
| Medical Orders Best practice/evidenced based practice will be initiated unle of evidenced based practice may not be eligible for OHaH ser reduced when appropriate. | | |
| Specify Wound: □Surgical □Malignant □Pilonidal □Traumatic □Ve | enous 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: International Control of the Control | al:cm External:cm | |
| □ Subcutaneous □Central Number of Lumens: □1 □2 □3 Drug: | _ | |
| Dose: Frequency: □ q24h □ q12h □ q8h □ q6h □ q4 | h Other: | |
| Duration of remaining community treatment:Days (n Last Dose in Hospital: Date: (dd/mm/yy)Time Community Therapy to Start: Date: (dd/mm/yy) | ne: | |
| 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 |
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