



Referral and Treatment Plan

- Chatham Site Sarnia Site Windsor Site
 Ph: 1-888-447-4468 Ph: 1-888-447-4468 Ph: 1-888-447-4468
 Fax: 519-351-5842 Fax: 519-337-4331 Fax: 519-258-6288

Community: _____

Hospital: _____ Unit: _____

Alternative Contact for Patient: _____

Relationship: _____ Phone: _____

Estimated Date of Discharge (dd/mm/yyyy): _____

Patient Demographics

Patient Name: _____

M F DOB: _____

(dd/mm/yy)

HCN: _____ VC: _____

Address/911: _____

City: _____ PC: _____

Phone: _____

Patient Agrees to Referral

Service Needed: (Assessment by Ontario Health atHome to determine services in clinic or home)

- Health links Nursing Palliative Care PSW Telehomecare Long Term care Dietician Social Work
 PT OT SLP e-Clinic (CKHA) Behavioural Support Ontario (BSO)

Reason for Referral: _____

Diagnosis: _____

NKA Allergies/ Sensitivities: _____

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

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

Start time may be delayed up to a max of 8hrs (recommended when 'Therapy to Start' time falls between 0000-0800 to avoid return to ED)

Signature

Print Name/Designation/Title

OHIP Billing Code 1

CPSO/CNO Reg. Number

Phone Number

Date (dd/mm/yy)