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North Simcoe Muskoka Local Health Integration Network

Medical Referral

Tel: (705) 721-8010 Toll free 1-888-721-2222 **Fax:** (705) 792-6270 Toll Free 1-866-700-1955

Addressograph or Label

Diagnosis: **Surgical Procedure/Date:**	**Patient Identification**: Name (surname, first name): Address:
Other Relevant Medical Hx:	Postal code: Phone number: DOB (yyyy/mm/dd):
Communicable Diseases: ☐ n/a ☐ yes specify:	HCN: VER: Alternate contact: Phone #:

Allergies: **Diabetes:** ☐ yes ☐ no

Prognosis: ☑ Improve ☐ Remain Stable ☐ Deteriorate ☐ Maintenance; Dx discussed with pt: ☐ yes ☐ no

Hospital Discharge List: ☐ attached ☐ Not Applicable

***Same day medication orders must be received by LHIN by 1300hrs**

Medication to be administered by LHIN	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 LHIN in Days

RNAO Best Practice Guidelines for IV Management will be followed unless specific orders are specified

IV Route Access Device: ☐ Peripheral ☐ CVAD ☐ IVAD - Type**:** _____

New Central Line Tip Confirmed ☐ **Yes (Documentation attached)** ☐ **Yes** ☐ **No**

1. **Peripheral:** 3mL N/S pre & post access; 2. **Non-Valved CVAD & IVAD:** 10-20 mL N/S and 5mL of Heparin 1:100 post access; or weekly if dormant 3. **Valved CVAD:** Flush and lock with 10-20mL N/S after each access; weekly if dormant; 4. **IVAD non-valved**: 10-20mL N/S and 5mL of Heparin 1:100 after each access; monthly if dormant; 5. **IVAD Valved**: flush and lock with 10-20mL saline

Service Requested	*Note: Treatments will be taught and services reduced when appropriate*	
☑ Nursing: Wound Care	*NOTE: Wound care orders outside of best practice may not be eligible for LHIN services. Wound care products may be substituted to a comparable product based on LHIN supply list* Wound Type: _____ ☐ Maintenance ☐ Healable ☐ Non-healable Wound Care as per Best Practice protocols ☐ yes (or please write wound care instructions below) Return to ER if worse, fever, concerns. Compression Therapy requires ABPI measurements ABPI _____ Date: _____ YYYY/MM/DD	
☐ Nursing - Other		
☐ Physiotherapy	Degree of Weight Bearing: ☐ None ☐ Partial ☐ Full ☐ Progression	
☐ Speech Therapy	☐ Occupational Therapy	☐ Personal Support Bathing, dressing, etc.
☐ Social Work	☐ Dietician	

☐ Long-Term Care ☐ Convalescent Care ☐ Adult Day Services

☐ **Lab:** (complete MOH Requisition) **NOTE:** Include Frequency **24hr phone # required** for results: (____) (____)-(____) Contact Name: _____	**Referring Primary Care Practitioner** **Name** (print)**:** _____ **Signature:** _____ **Phone:** (705) (444)-(8606)OHIP Billing #_____ Date: _____ YYYY/MM/DD