Paediatric (under 18 years of age) Medical Referral (revision dated December 2017)

North Simcoe Muskoka Local Health Integration Network
15 Sperling Drive, Barrie, ON L4M 6K9
Tel: (705) 721-8010 Toll Free 1-888-721-2222
Fax: (705) 792-6270

Patients may have care in a nursing clinic and be taught their treatments based on nurses discretion.
This document will be included in the Patient record.

Paediatric Demographics		
Name:		
Parent/Guardian Name:		
Address:		
City:	Postal Code:	
Phone:	DOB: (yyyy/mm/dd)	Sex:
HCN:	Ver:	
Weight:	**Kg**	
Height:	**cm**	
Alternate Contact Name:		
Alternate Contact Phone:		

Allergies: (drug, environmental, animal, food)

Diagnosis: (most relevant to care in community)

Diagnosis discussed with Family/Guardian ☐ Yes ☐ No Patient ☐ Yes ☐ No

Prognosis: (Improve, Remain stable, Deteriorate, Guarded)

Prognosis discussed with Family/Guardian ☐ Yes ☐ No Patient ☐ Yes ☐ No

Other Diagnosis/Presenting Problem:

Surgical Procedure or Treatment:

Current Medications: ☐ (attach current list) N/A ☐

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

Medication to be administered	Limited Use(LU) Code	Dosage	Frequency	Route	Last Dose in Hospital: Date/Time	Next Dose in Community: Date/Time	Length of Therapy in Days

IV Route Access Device:

☐ Peripheral ☐ CVAD single lumen ☐ CVAD double lumen

☐ Implanted Vascular Device
Type/Comment:

Is there Radiological confirmation of tip placement of new central line?
☐ Yes **(Documentation attached)**

Heparinization Dosing Guidelines Reference:

Weight	Dose of Heparin	Heparin Product used	Total volume	Minimum Frequency	Maximum Frequency
Less than or equal to 10kg	10 units/kg	Dilute heparin 100units/mL with normal saline to total volume of 1 mL	1mL each lumen	Every 24 hours	Three times daily
Greater than 10kg	100 units/kg	100 units/mL	1mL each lumen	Every 24 hrs	Three times per day if patient is receiving a systemic anti-coagulation

Other Medical Orders:

Requested Services to be Assessed by LHIN:
☐ Nursing ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Dietician ☐ Social Work
☐ Respiratory Therapy ☐ Lab (Patient has requisition and instructions)
Comments:

Signature of Physician/Nurse Practitioner:

Print Name: Signature: Phone: Date: CPSO #:

Alternate Most Responsible Physician/Nurse Practitioner:

Name: Phone:

Telephone Order From Physician/Nurse Practitioner:

Taken By (print): Signature: Phone: Date of telephone order:

Fax completed LHIN referral form to **(705) 792-6270** on: