Home and Community Care Support Services Champlain - Medical Referral Form

Orders are fulfilled per Community Protocols documented on page 2, unless physician requests otherwise. We process only completed referrals (signed, dated and legible). Confidential when completed. Fax completed form to 613.745.6984 or 1.855.450.8569. If you received this form in error, please call 1.800.538.0520.

PROCEDURES WILL BE TAUGHT TO PATIENT OR RELIABLE PERSON **When appropriate, patient are referred to Community Nursing CLINIC instead of HOME VISIT**	Name* Address Date of birth	Phone* HCN* / v.c. CEL Phone

ALLERGIES	Preferred language for service: FRE ☐ ENG ☐ Other ☐
INFECTION CONTROL PRECAUTIONS: ☐ DROPLET ☐ AIRBORNE ☐ CONTACT ☐ ROUTINE	**Hospital Planned Discharge Date:**
☐ Please use alternate contact (rather than the patient) for assessment, due to: ☐ Preference ☐ Hearing ☐ Cognition ☐ Language ☐ Other	

Alt Contact Person	**Relationship**	**Phone**

DIAGNOSIS:

WOUND: ☐ Initiate or Continue with Home & Community Care Support Services evidence-based wound care

Location and Measurements: _____Date of last dressing change:_____

Packing ☐ Yes ☐ No Type & Size of Packing_____Length of packing inserted:_____# of Pieces inserted_____

COMPRESSION therapy: (1)_____ABPI/TBI:_____

Compression wraps for venous insufficiency are supplied for a **maximum of 6 weeks**, then client will be transitioned into a reusable form of compression. Compression is not provided for Lymphedema management.***

PLEURAL EFFUSION / ABDOMINAL DRAINAGE FOR MALIGNANCIES ONLY (**2**): **Patient had pleuroscopy** ☐ Yes - insertion date:

☐ **Lung** ☐ **Abdomen** Drain up to__mLs_____times a week & PRN **Remove sutures:** ☐ Yes Date:_____☐ No ☐ PleurX ☐ Other:_____

TOHCC CHIPP PROTOCOL (3): ☐ Yes -Tentative Start Date:_____See reverse for protocols

INDWELLING CATHETER (4): Insertion Date:_____Size:_____☐Silicone-coated Latex ☐Silicone ☐Coude/Tiemann (100% silicone)
☐Other_____(specify) **(Note: if size/type not specified, will default to size 16 FR, silicone catheter changed q3 months)**

PROTOCOLS

☐ **Nephrostomy Tube (5A)**	☐ **Percutaneous Tube (5B**) Irrigation with NS, MUST indicate: Amount _____Frequency _____	☐ **Ostomy Care (6)** **ADP Form completed?** ☐ YES ☐ NO **Starter kit provided by hospital?** ☐ YES ☐ NO

OTHER ORDERS	**Rapid Response Nursing** (RRN) **(7)**: ☐ YES Patient Medication List **MUST** be attached to this referral

MANDATORY List all **medications for Medication Reconciliation Purposes**: use separate sheet if required

Physician/NP Name: (please print)	CPSO/college # *Required for Prescription Medications
Physician/NP signature:	Date:
If delegate, name of attending physician:	Telephone:

By signing this document, I (physician/NP) have reviewed the community protocols on the reverse of this form, and agree with this procedure or have specified other procedure above.

Other Service Needs

☐ **Physiotherapy**	Degree of Weight Bearing ☐ None ☐ Partial ☐ Full ☐ Progression	☐ **Occupational Therapy** ☐ **Dietician** ☐ **Speech Language Therapy** ☐ **Social work**	☐ **Personal Support Service** ☐ Linking to community resources/supports
Height (if walker req):		**Please attach any pertinent hospital assessment information**	

Referring Health Professional Name:	Date:	Phone

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1) COMPRESSION

Compression is provided in the following circumstances:

a) **Venous insufficiency with a wound**: compression will be provided using disposable wraps for a **maximum of 6 weeks**, at which point, if the wound is still present, the client will be transitioned into a reusable form of compression.

b) **Venous insufficiency and large to gross edema, NO wound**: compression will be provided using disposable wraps for a maximum of 6 weeks, at a frequency of no more than 2x/week, to reduce edema with the expectation that the patient will purchase a compression garment (i.e. stockings) for self-management. Compression wraps are not provided ongoing for edema prevention/management.

2) PLEURAL EFFUSION/ABDOMINAL DRAINAGE FOR MALIGNANCIES ONLY

Pleural CATHETER DRAINAGE	**Pleural CATHETER DRESSING CHANGE**
a) Complete drainage as per policy and procedure for lung or abdomen. b) Do not drain more than 1000 mL per drainage procedure for the lung effusion or more than 4000 mL for the abdominal drainage, unless otherwise prescribed by physician. c) If drainage is < 50 mL for 3 consecutive drains and the patient is not symptomatic, contact the Malignant Effusion Program for a follow-up appointment at (613-737-8899 extension 79987). d) Discontinue drainage if patient experiences pain or dyspnea that is not relieved by slowing or stopping the drainage process.	a) Complete dressing change as per policy and procedure at the time of chest tube drainage and PRN. b) If chest tube is not being drained, change dressing twice a week and PRN (e.g. no longer intact or soiled). c) If patient is allergic to dressing assess and page "Pleural Effusion Nurse On Call" at 613.737.8899

3) TOHCC CHIPP STANDING ORDERS

a) Initiate CHIPP Symptom Management Guidelines b) Discontinue 5-FU infusion on the final day of radiation therapy c) Patient will receive first nursing visit on day of disconnect regardless of duration of infusion.	**CHIPP Infusion Orders:** a) If residual volume present at any time of disconnect, assess potential reasons for delay, provide appropriate patient education and return in five hours to disconnect. b) If residual remains after additional five hours of infusion, notify PDN and Care coordinator, disconnect and complete the CHIPP Delay Infusion form

4) INDWELLING CATHETERS OR SUPRAPUBIC CATHETERS

a) Change silicone-coated **latex** catheter monthly and PRN	b) Change **silicone** catheters every 3 months and PRN	c) Irrigate catheter with 50-150mL Normal Saline PRN to assess for patency; not supported by evidence to be performed routinely

If size/type not specified on medical referral, standard Foley catheter kit will be provided with 16 FR silicone catheter

5) PERCUTANEOUS TUBES

5A) NEPHROSTOMY TUBES	**5B) PERCUTANEOUS TUBES** (e.g. Biliary Catheter or Draining Abscess)
a) Using sterile procedure, irrigate the catheter with no more than 10mL of Normal Saline 2 x/wk and PRN (daily if patient or family can do it). **Do not aspirate**. b) Clean catheter insertion site with non-alcohol Chlorhexidine and apply dressing (gauze and transparent dressing or drain attachment device and transparent dressing) weekly and PRN. c) Change extension tubing, stopcock and bag every 2 weeks and PRN.Monitor catheter insertion site for infection.	**PHYSICIAN must specify amount and frequency of irrigation** a) Clean catheter insertion site with non-alcohol Chlorhexidine and apply dressing (gauze and transparent dressing or drain attachment device and transparent dressing) weekly and PRN. b) Change extension tubing, stopcock and bag weekly and PRN. c) Monitor catheter insertion site for infection.

6) OSTOMIES

New Ostomies: 4 visits over 6 weeks to **teach** client or family-member ostomy management skills**.** Supplies provided for 30 days only.

Established Ostomies: Assess and address specific issue, then **teach & discharge.** No supplies provided unless wound impacting flange adhesion, and then short-term only.

7) RAPID RESPONSE NURSING

For hospital to home discharges of complex frail adults and seniors to reduce re-hospitalization and avoidable emergency department visits. Patient Medication List at discharge from hospital must be attached to this referral.