

Mississauga Halton LHIN Referral Form

Anyone can make a referral to the LHIN...Physician signature only required for Nursing and Physiotherapy Weight Bearing Please Note: To ensure patient safety and continuity of care, please ensure the LHIN referral is completed in full Palliative referrals: Please send separate Palliative referral form CS PAL

Referral information: <input type="radio"/> Community Referral <input type="radio"/> Hospital Referral Planned Date of hospital discharge: Name of person referring: Contact Information: Reason for Referral: Diagnosis/Significant Medical Information:		Patient Demographics: affix label if appropriate Patient Name: Home Address: DOB: _____ HCN: _____ Phone: _____ Gender: <input type="radio"/> Male <input type="radio"/> Female Allergies: Diabetic: <input type="radio"/> Yes <input type="radio"/> No	
Service Requested	Note: Treatments will be taught and services reduced when appropriate Wound care products may be substituted to a comparable product based on MH LHIN supply formulary		
<input type="checkbox"/> Nursing - Wound Care Ambulatory Patients will receive their nursing care in a LHIN Nursing Clinic.	For all wound care order include wound etiology and wound dimensions <input type="checkbox"/> Nursing to Assess and Treat <input type="checkbox"/> Specific Wound Care Orders:		
<input type="checkbox"/> Nursing - IV	IV Medication: Name of Medication: _____ Dose: _____ Frequency: _____ Duration: _____ Date & Time Last Dose Given: _____ Route: <input type="radio"/> PICC <input type="radio"/> Port-A-Cath <input type="radio"/> Peripheral IV		Screening for 1st dose administration at home 1) History of serious adverse or allergic reaction to the prescribed medication or related compound? <input type="radio"/> Yes <input type="radio"/> No 2) Patient currently on beta-blockers, A.C.E Inhibitors and anti-adrenergic drugs? <input type="radio"/> Yes <input type="radio"/> No If NO to both above - Ok to administer 1st dose in home? <input type="radio"/> Yes <input type="radio"/> No
IV Access Route Care: (All Heparin orders please indicate in IV Additional Specific orders)	<input type="radio"/> Peripheral: Flush 2-3cc 0.9% NS OD Tubing Change: Q3 Days Dressing: Q weekly PRN		
	<input type="radio"/> Valved PICC: Flush 0.9 % NS 10 ml <input type="radio"/> Non-Valved PICC: Flush 0.9% NS 10ml followed by 300 units of Heparin. Frequency: after each access or weekly if not it use Frequency: after each use or weekly if not in use. Dressing & Cap Change: Q weekly PRN Dressing and Cap Change: Q weekly &PRN		
	<input type="radio"/> Port-a-cath: Flush 0.9% NS10-20/ml followed by 500 units of Heparin Frequency: After each use or every 4 weeks if not in use. Dressing & Gripper Change: Q7 weekly & PRN Gripper Size:		
	IV Additional Specific Orders: (eg: Hickman, Midline, any additional Heparin orders)		
<input type="checkbox"/> Nursing – Other e.g. Catheter, Ostomy, drains, etc.	Foley Catheter Care: Type of Catheter (i.e., coude, silicone, etc.): _____ Size (i.e., 14fr, 16fr.): _____ Date of Insertion: _____ Frequency of Change: _____ Additional orders (:e.g., trial void): _____ Other Nursing Orders: _____		
<input type="checkbox"/> Physiotherapy	Degree of Weight Bearing: <input type="radio"/> Partial <input type="radio"/> Full <input type="radio"/> Progressive <input type="radio"/> None		
<input type="checkbox"/> Speech Language Pathology	Indicate area of need as applicable for any Service Request:		
<input type="checkbox"/> Occupational Therapy			
<input type="checkbox"/> Personal Support (e.g., bathing, dressing)			
<input type="checkbox"/> Social Work			
<input type="checkbox"/> Dietetic Service			
<input type="checkbox"/> Rapid Response Nurse			
<input type="checkbox"/> Navigation to Community Supports			
<input type="checkbox"/> Caregiver Respite			
<input type="checkbox"/> Assessment	<input type="checkbox"/> Long Term Care <input type="checkbox"/> Short Stay <input type="checkbox"/> Convalescent <input type="checkbox"/> Adult Day Program		
<input type="checkbox"/> Health Links	<input type="checkbox"/> Lives Alone <input type="checkbox"/> Limited social network <input type="checkbox"/> Community Service Use <input type="checkbox"/> Finances <input type="checkbox"/> Transportation <input type="checkbox"/> Housing <input type="checkbox"/> Mobility <input type="checkbox"/> Home Bound		
Physician/NP Signature required for Nursing and PT weight bearing: Print Name and Phone number:		Billing Code:	Date: