



Fax to:

Kirkland Lake 705 567 9407	North Bay 705 474 0080	Parry Sound 1 855 773 4056	Sault Ste. Marie 705 949 1663	Sudbury 705 522 3855	Timmins 705 267 7795
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☐ PATIENT IS AGREEABLE TO REFERRAL.					
Health Card Number:		Version Code:		Date of Birth (DD/MM/YYYY):	
Surname:		First name(s):			
Address:		City:		Province:	Postal Code:
Phone #:		Primary Language: ☐ English ☐ French ☐ Other (specify):			
Gender: ☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown		Weight (kg):		Height (cm):	
Name of Contact Person (if other than Patient):					
Phone #:		Relationship: ☐ POA/SDM ☐ Spouse ☐ Other (specify):			
Relevant diagnosis:			Reason for Referral:		
Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate Planned Hospital Discharge Date (DD/MM/YYYY):					
Location and Type of wound (if any):					
Infection control: ☐ MRSA Positive ☐ VRE Positive ☐ C-diff ☐ TB ☐ Other (Specify):					
Surgical Procedure:			Surgical Date (DD/MM/YYYY):		
Weight bearing status: ☐ Full-weight ☐ Non ☐ Partial Activity/Mobility Restrictions:					
SERVICES REQUESTED					
☐ Nursing			☐ Enterostomal Therapist/NSWOC		
☐ Personal Support			☐ Rapid Response Nursing (Sudbury, Manitoulin, Espanola, North Bay, Sault Ste. Marie, Timmins, Parry Sound)		
☐ Occupational Therapy			☐ Telehomecare Nursing		
☐ Physiotherapy			☐ Social Work		
☐ Dietetics			☐ Speech-Language Pathology		
☐ NP Primary Care (Sudbury, North Bay, Sault Ste. Marie) ☐ NP Palliative Care (Sudbury, Manitoulin, West Nipissing, Kirkland Lake, Sault Ste. Marie, Timmins)					
☐ Community Transition Nursing (Sudbury, Espanola, Parry Sound, North Bay, Kirkland Lake, Timmins, Sault Ste. Marie)					
INFUSION THERAPY ORDERS: Care Coordinator will coordinate pharmacy dispensing. Radiologic Report confirming PICC line placement is required.					
MEDICATION #1: Drug: Dose: Frequency:					
Route: ☐ Subcutaneous ☐ Peripheral IV ☐ Central Line type: # Lumens:					
Date/Time Initial Dose Given (DD/MM/YYYY):			Date/Time Next Dose Due (DD/MM/YYYY):		
# Days Remaining:			Limited Use Code:		
MEDICATION #2: Drug: Dose: Frequency:					
Route: ☐ Subcutaneous ☐ Peripheral IV ☐ Central Line type: # Lumens:					
Date/Time Initial Dose Given (DD/MM/YYYY):			Date/Time Next Dose Due (DD/MM/YYYY):		
# Days Remaining:			Limited Use Code:		
Site Care: ☐ As per Best Practice Guidelines Canadian Vascular Access Association and Registered Nurses Association of Ontario ☐ Other (Specify): Next dressing change due (DD/MM/YYYY):					
Flush Instructions: ☐ Local Nursing Provider Protocol ☐ Other (Specify):					
For High Risk Medications Vancomycin/Aminoglycosides: ☐ Lab Requisition Provided to Patient					
Date of Last Blood Work (DD/MM/YYYY):		Time (HH/MM):		Serum Creatinine Results:	
Trough Level:		Blood Urea Nitrogen Level:		Date of Next Blood Work Due (DD/MM/YYYY):	
Wound Care Orders: (Wound Care Pathways)					
☐ Initiate wound-specific clinical pathways					
☐ Wound Care as follows:					
☐ Negative Pressure Wound Therapy (NPWT)		Dressing Size: ☐ Small ☐ Medium ☐ Large ☐ Extra Large			
Foam Type:		Cycle: ☐ Intermittent ☐ Continuous Pressure Setting mmHG:			
In the event of NPWT failure, please provide back-up orders:					

As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

☐ Additional Notes relating to the referral provided, see attached.

Health Care Practitioner Name

CPSO #

Signature/Designation

Date (DD/MM/YYYY)

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Additional Notes relating to the attached Referral for Services *for*:

Surname:

First name(s):

Date of Birth (DD/MM/YYYY):

Health Care Practitioner Name_____
CPSO #_____
Signature/Designation_____
Date (DD/MM/YYYY)