HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Hamilton Niagara Haldimand Brant

# Request for Home and Community Care Support Services
## Hamilton Niagara Haldimand Brant

**Patient Name** _____ **HCN** _____ **VC** _____ **DOB** _____

**Address** _____ **City** _____ **Province** _____ **Postal Code** _____

**Patient Phone** _____ **Contact Name** _____ **Contact Phone** _____

☐ **Community:** Fax completed form to 1-866-655-6402 ☐ **Hospital:** Fax completed form to hospital HCCSS HNHB office (see pg. 2);

**Hospital Referrals:** Unit/floor _____ Planned Hospital Discharge Date _____

☐ **Bundle Holder Referral for Service** – Hospital Site _____ Bundle Type _____

☐ **The patient or lawfully authorized substitute decision maker has consented to this referral**

☐ **Please contact the person below (rather than the patient) for assessment, due to:**

☐ Patient Preference ☐ Hearing Difficulties ☐ Cognitive Status ☐ Language Difficulties ☐ Other _____

**Contact Person** _____ **Relationship** _____

**Phone (Home)** _____ **Phone (Cell)** _____ **Phone (Work)** _____

**Primary Care Physician** _____ **Phone** _____

**Primary Diagnosis** _____ **Date** _____

**Secondary Diagnosis** _____ **Diagnosis Discussed** With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No

**Prognosis** ☐ Improved ☐ Remain Stable ☐ Deterioration **Prognosis Discussed** With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No

**Surgical Procedure** _____ **Date** _____

**Current Medications** ☐ Medication List Attached ☐ Health Profile Attached **WSIB Claim** ☐ Yes ☐ No

**Allergies** _____ **Special Diet** _____

**Wound Care** (Include location)_____

*Note: If not specified, nurse will assess and provide recommendations. Wound care products may be substituted to a comparible product based on HNHB supply list.*

**Weight Bearing** ☐ Full ☐ Partial ☐ Feather ☐ None **Activities Permitted** _____

**Completion of additional forms are required for the following protocols** *(select link to open form)*:
Central Vascular Devices | Vancomycin & Aminoglycoside Prescriptions | Protocol for First Dose IV

| | | |
|---|---|---|
| ☐ Activities of Daily Living | ☐ Behavioural Supports (e.g. BSO) | ☐ Chronic Disease Management |
| ☐ Community Support Services/ Resources | ☐ Dementia/ Memory Impairment | ☐ Health Link Patient |
| ☐ Home Safety | ☐ Housing Options | ☐ Medication Management |
| ☐ Mobility/ Risk of Falls | ☐ Pain Management | ☐ Palliative Care/ End of Life - PPS% _____ |
| ☐ Social Isolation | ☐ Strengthening | ☐ Speech Language Pathology |

**Medical Orders:** ☐ **Same Day Request** ☐ *Additional information attached. Total Number of Pages* _____

☐ **Indwelling Urinary Catheter Care:** Insertion Date: _____ Size: _____ Type: _____

Standard maintenance for Indwelling or Suprapubic Catheter: Change latex catheter monthly and PRN, Change silastic and silicone – silicone coated catheters every 3 months and PRN. Irrigate catheter with 50-100 mL Normal Saline PRN.

*Note: if size/type not specified, standard foley catheter kit will be provided with #14 & 16 silicone coated catheter for nurse to use discretion*

Thank you for your referral. The Home and Community Care Support Services Hamilton Niagara Haldimand Brant will assess and work with your patient to develop a care plan that includes service location, frequency and health teaching to support independence. For questions please call 1 800 810 000 from 8:30 am to 8:30 pm, 7 days a week.

**Name** Dr Rafi Setrak (Please Print) ☑ **MD** ☐ **NP** **Telephone** _____

**Signature** _____ **Date** _____ **CPSO/CNO Reg. #** 81883

Ontario

Version **23-001**