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 _____ ☐ **MD** ☐ **NP** **Telephone** _____
(Please Print)

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

Ontario