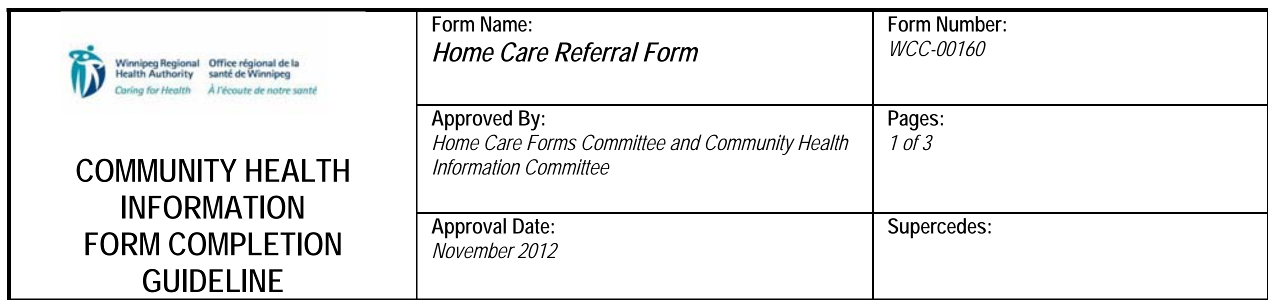


Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE	Form Name: *Home Care Referral Form*	Form Number: *WCC-00160*
	Approved By: *Home Care Forms Committee and Community Health Information Committee*	Pages: *1 of 3*
	Approval Date: *November 2012*	Supercedes:

INTENT/PURPOSE OF FORM

- To refer clients to the Home Care Program. Please note that the Winnipeg Integrated Services (WIS) referral form will continue to be used by WIS partners.
- Form titled "Nursing Only Form" was previously used for the purpose of referring clients.

DEFINITIONS

- Central Intake: is part of the Provincial Health Contact Centre and is responsible for determining eligibility for a program assessment.

- Central Nursing Intake: is part of the Provincial Health Contact Centre and is responsible for determining eligibility for Home Care Nursing services.

- After Hours Service: is part of the Provincial Health Contact Centre and is responsible for determining the need for Home Care services during the times outside of regular office hours (i.e. Monday to Friday 4:30 p.m. to 8:30 a.m., and weekends and statutory holidays).

USED BY

- Home Care Hospital Case Coordinators.

- Physicians.

- Emergency Departments outside regular office hours.

- Interim Housing at Misericordia Health Centre for referral of clients being placed in Supportive Housing complexes.

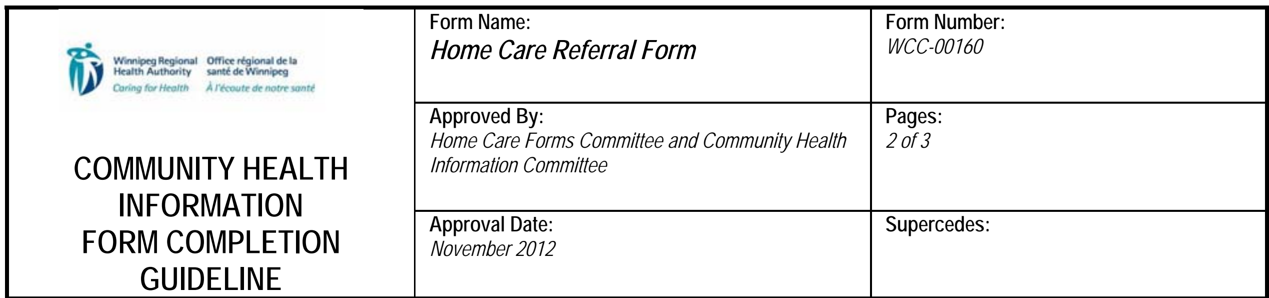
GUIDELINES FOR COMPETION OF FORM

- **Client Demographic Information**: fully complete the upper right hand corner with the identification and contact information of the client, or attach a client label.

- **Fax To**: indicate in the check box the area to which the referral is to be faxed. Indicate the facility or community area, if known.

- **Service(s) Requested**: describe the services that are being requested, and the date the services are to begin, if applicable.

- **Service Address** (if different from above): if client will be staying at an alternate address, indicate their temporary address, including the phone number for the temporary address.



- **Client's Primary Contact Name**: indicate the person to be contacted on client's behalf, their relationship to the client and telephone number.

- **Languages**: indicate the language(s) spoken and understood by client.

- **Medical Diagnoses**: include relevant medical information.

- **Allergies**: indicate allergies.

- **Treatment/Medical Orders**: indicate treatment /medical orders. If not enough space, check "See attached if applicable" and attach signed treatment /medical orders to referral form.

- **Medication Orders**: transcribe medication orders from prescriber or check "See attached if applicable" and attach signed medication list to referral form.

- **Medications will be in Home**: indicate if medications are in the home and, if not, indicate plans to access medications.

- **List Other Programs/Services Involved**: indicate if other agencies are involved, including phone and fax numbers (e.g. Community Disability Services, Employment and Income Assistance). Attach a list if more room is needed.

- **Living Arrangements**: check boxes as applicable.

- **Family Support Available**: check box to indicate if family supports are available or not.

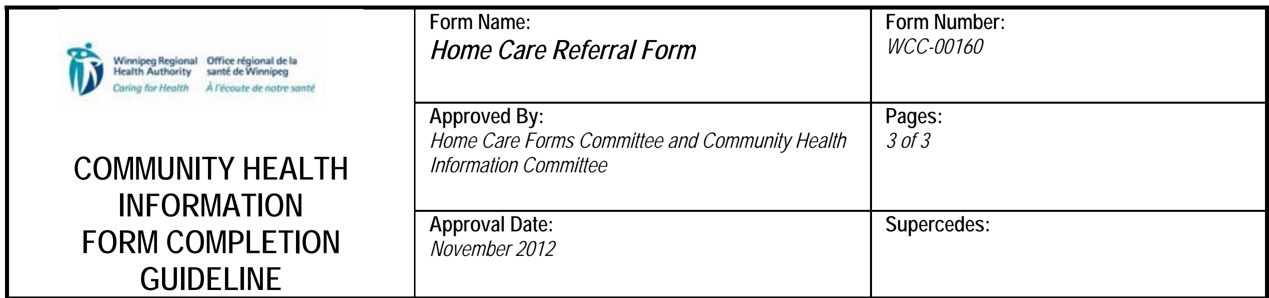
- **Safety**: indicate if there are any possible threats to the safety of Home Care staff.

- **Communication**: check boxes to indicate if vision, hearing, or speech impairment is present or not.

- **Daily Living**: check boxes to indicate whether client or and family is able to perform the identified tasks.

- **Mobility**: check relevant box and, if not identified, indicate what other method of mobility under "Other."

- **Continence**: check box as applicable; identify any other issues under "Other."



- **Cognition and Behavioral Issues**: check boxes as applicable; identify any other concerns not listed under "Other."

- **Comments**: add any other relevant comments.

- **Physician's Name and Address**: include the name of the Attending Physician or the Primary Care Physician, whoever is providing the Treatment/Medication Order. Include their address, phone and fax.

- **Name of Referral Source**: include name of individual who is referring client, with phone and fax.

- **Signature & Designation**: include signature and designation of Referral Source, including date.

FILING/ROUTING INSTRUCTIONS

- File in section 1 of the Home Care office paper file.

PRINTING INSTRUCTIONS

- Single form must be printed from INSITE.

AUTHOR:

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