Vancouver CoastalHealth

Home Health Referral Form

Instructions:

1. * Mandatory fields
2. Attach orders (if required)
3. Signature required before submission

Home and Community Care Access Lines

Vancouver (604) 263-7377 | Fax (604) 267-3419
Richmond (604) 675-3644 | Fax (604) 278-4713
North Shore (604) 983-6700 | Fax (604) 983-6886

Referral Source Information

Referrer Name

*LAST	*FIRST	*RELATIONSHIP TO CLIENT
*PHONE NUMBER	*FAX NUMBER	EMAIL
Has the client or alternate decision maker given consent for this referral? ☐ YES ☐ NO *if no, please explain:		PRIMARY CARE PROVIDER (if applicable)

Client Information

*LAST (Legal)	*FIRST	MIDDLE
*DATE OF BIRTH (YYYY/MM/DD)	*PERSONAL HEALTH NUMBER	*SEX
*MARITAL STATUS	INDIGENOUS IDENTITY	*GENDER IDENTITY
*PRIMARY LANGUAGE	*INTERPRETER REQUIRED ☐ NO ☐ YES	

*ADDRESS (Unit#/ Buzz#)	*CITY	*POSTAL CODE	*PROVINCE

*PRMARY PHONE NUMBER	*SECONDARY PHONE NUMBER	EMAIL
*ALTERNAL CONTACT NAME	*RELATIONSHIP TO CLIENT	*ALTERNATE CONTACT PHONE NUMBER
*REFERRAL: ☐ **URGENT** ☐ **NON-URGENT**		ALTERNATE CONTACT EMAIL

Reason for Referral to Home Health *(see back of referral form for Home Health Services that require orders or Treatment plan)*

*What specific change or event has led to initiating this referral? ☐ Orders or treatment plan completed, signed and attached

*Relevant Medical History/Conditions (e.g. cognition, functional status, etc) ☐ see attachment(s) e.g. Medical Summary

*Allergies ☐ NO ☐ YES *if yes, please list*

Palliative Home Health Services *(complete this section if the client would benefit from a palliative care approach)*

☐ B.C. Palliative Care Benefits signed ☐ CPR form completed	☐ Advanced Care Planning (ACP) ☐ Goals of Care (GOC)

Referring Medical Provider SIGNATURE

*PRINT NAME	*SIGNATURE	DATE *(yyyy/mm/dd)*

HOME HEALTH SERVICES

Home Health Services are offered to clients and/or caregivers for the purposes of restoring or maintaining independence in the home and include:

- Case Manager
- Community Health Nurse
- Ambulatory Care Nursing (services provided in a clinic setting)
- Occupational Therapist
- Physiotherapist
- Social Worker
- Dietician
- Speech Language Therapist
- Spiritual Health Practitioner

Once your client is connected with Home Health, the Home Health clinician may connect them with the following programs if needed:

- Home Support
- Overnight Respite
- Palliative, End of Life & Hospice Care
- Choice in Supports for Independent Living (CSIL)
- Adult Day Programs
- Family/Caregiver Support
- Speech-Language Pathology & Swallowing Assessment Services
- Long Term Care, Assisted Living

ORDERS

The following Home Health services require an order from an authorized prescriber (attach complete orders with the referral):

- Catheter Care
- Trial of Void
- Management of drains or tubes
- Tracheostomy management
- IV Therapy

TREATMENT PLANS

Treatment plans are accepted for the following interventions (Note: Treatment Plans are optional):

- Wound Care
- Mobility
- Continence management (including ostomy)
- Pain management through measures other than medication (e.g. positioning, movement)