Vancouver Coastal Health
Promoting wellness. Ensuring care.

VANCOUVER PAEDIATRIC TEAM **(VPT)** NURSING REFERRAL

Tel: 604-267-2606

DATE: _____

PHN: _____

The below-named is being referred to the Vancouver Paediatric Team for homecare nursing. As permitted by the **Freedom of Information and Protection of Privacy Act**, we are requesting that copies of his/her records that are pertinent to the care of the client be forwarded to the fax number or email at the bottom of the form.

PATIENT DETAILS

Name: _____ **DOB:** _____

Gender Identity: **M** ☐ **F** ☐ **Non-binary** ☐ Other: _____

Permanent Address: _____

Primary Contact (name): _____ **Relationship:** _____

Tel (cell): _____ **Tel (home):** _____ **Email:** _____

Parent/Guardian name if different then above: _____

Tel: _____ **Email:** _____

PLEASE PROVIDE ANY RELEVANT SOCIAL HISTORY:

Social work involvement:

Name: _____ **Contact:** _____

Other: _____

COMMUNICATION

Language: _____

Need for translator? Y ☐ N ☐

Client/Family has consented to referral? Y ☐ N ☐

MEDICAL HISTORY AND DIAGNOSES (please list all current diagnoses & any recent surgeries**)**

Diagnoses:

History:

If the client is palliative, please submit referral for NSS direct care: http://www.bcchildrens.ca/health-professionals/ refer-a-patient/nursing-support-services-referral

CURRENT MEDICATIONS: (attach list if available**)**

ALLERGIES:

REASON FOR REFERRAL

☐ **Wound Care** ***(Eligibility: Child is currently followed by VPT Nursing Team, or 0-10 years old, or 10+ years old but unable to attend an ambulatory clinic. If the answer to any of the above statements is no, please call Vancouver Home and Community Care intake office at 604-263-7377.)***

☐ **Follow-up Education & Teaching/Team that provided training** ***(completed in hospital)***

☐ **Other:**

PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION

Physician's Signature (Physician order is required for medication administration)

Date: _____ **Phone:** _____

PERSON SUBMITTING REFERRAL

Name: _____ **Title:** _____ **Phone:** _____ **Fax:** _____

Organization/Office: _____ **Email**: _____

PLEASE **EMAIL** COMPLETED REFERRAL **TO** VPTIntake@vch.ca