



Home Care Treatment Clinic Referral (Manitou)

Hours Open: Tuesday, Friday - hours as determined by case load

Services Provided: **Wound Care, CVAD care,
Urinary Catheterizations, Injections**

MHSC# _____ PHIN# _____

Date of Referral: _____ **Start Date Requested:** _____

Client's Name: _____ **Date of Birth:** _____

MHSC # _____ **PHIN #:** _____

Street Address: _____ Postal Code: _____

Contact numbers: Home _____ Work: _____ Cell: _____

Primary contact person: _____ Phone: _____

Family Physician: _____ Phone: _____

Is a WCB claim involved? Yes No

Is an MPIC claim involved? Yes No

Medical Diagnosis:

Treatment/Medical/Physician orders: (Signed Physician Orders Attached)

Date: _____ **Physician Signature:** _____

Allergies: No Yes, specify: _____

MRSA positive: No Yes **VRE positive:** No Yes **C- diff suspect:** No Yes

Ambulation

Cognition

Living Arrangement

- Independent
- Independent with aid
- Needs assist
- Wheelchair independent
- Wheelchair with assist

- Orientated
- Confused occasionally
- Depressed
- Anxious
- Other

- Alone
- Married
- Widowed
- With relatives
- With others,specify _____

Sensory & Aides

Language Spoken

- Speech impairment Yes No
- Vision impairment Yes No
- Hearing impairment Yes No

- English
- Other _____

Completed by: _____
Nurse Signature

Date: _____