Home Care

Treatment Clinic Referral
(Portage)

Phone 204-857-6183 ***Fax 204-239-2443***

Hours Open: **9am - 5:15pm open 7 days/week** * Please fax completed referrals*

Services Provided: ***Wound Care, IV Anti-Infective Therapy, CVAD care, Urinary Catheterization, 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:

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

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Date: ____________________ **Physician Signature:** ________________________________

Allergies: ☐ ***No*** ☐ ***Yes, specify:*** ____

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

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

Cognition
- ☐ Orientated
- ☐ Confused occasionally
- ☐ Depressed
- ☐ Anxious
- ☐ Other

Living Arrangement
- ☐ Alone
- ☐ Married
- ☐ Widowed
- ☐ With relatives
- ☐ With others,specify______________________

Sensory & Aides

Speech impairment ☐ Yes ☐ No
Vision impairement ☐ Yes ☐ No
Hearing impairment ☐ Yes ☐ No

Language Spoken
- ☐ English
- ☐ Other ________________________________

Completed by: ______________________________ **Date:** ____________________

Nurse Signature

Oct-15