Home Care

Treatment Clinic Referral

(Steinbach)

Phone 204-346-7005 **Fax 204-326-2506**

Hours Open: **8:00am-8:00pm 7 days/Week** *Please fax completed referrals*

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

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: ______________________

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