WEST PARK HEALTHCARE CENTRE

Addressograph

Inpatient Referral Form
Tuberculosis Service/2 East B

Return by Fax: 416-243-3684

Please Complete This Form in Full and Fax With Required Documentation to the Attention of:

Sharon Stewart, Care Coordinator

Phone: 416-243-3600 ext 4054

Name of Patient	**D.O.B**
Current Location	
Home Address	
Phone	

Required Documentation — *Incomplete Referrals Will Not Be Processed*

- ☐ Typed Medical History & Physical Report
- ☐ Current MARS
- ☐ All Consultant Reports
- ☐ All Blood Work
- ☐ All Public Health Lab Reports
- ☐ Results of All Investigations
- ☐ All Medical Imaging Reports i.e., CXR, CT Scan, MRI, Ultrasound …

Referring Physician:	**Phone:**
Referring Facility:	**Phone:**
Contact Person:	**Phone:**
Nursing Unit:	**Phone:**
Family Physician:	**Phone:**
Referring Public Health Unit	**Phone:**

Reason for Referral (check all that apply)

- ☐ Living with Immuno Compromised individuals or Young Children
- ☐ Homeless
- ☐ Shelter user
- ☐ Section 22
- ☐ Drug Resistance
- ☐ Co-morbidities
- ☐ Section 35
- ☐ Overwhelming Disease
- ☐ Drug Toxicities
- ☐ Positive smears
- ☐ Other

Recent Lab Tests (less than 3 days prior to transfer)

CBC/Sed Rate/Creatinine/BUN/Electrolytes/Liver enzymes

Drug Susceptibilities – If Known

Drug Sensitive: **Y N** Drug Resistant: **Y N**

If **Yes**, specify Resistant Pattern _____

MDR: **Y N**

If **Yes**, specify Resistant Pattern _____

For MDR Patients, please have PICC line inserted prior to admission to TB Service. If PICC in situ, please do not remove

TB Diagnosis

Pulmonary: **Y N** Extra Pulmonary: **Y N**

If yes, Site(s) _____

Both: **Y N** Site(s) _____

Drug Allergies

Associated Infections

HIV: ☐ Negative ☐ Positive ☐ Pending Test Date _____

Please forward HIV Test result to WPHC when received

Hep B: ☐ Negative ☐ Positive

Hep C: ☐ Negative ☐ Positive

MRSA: ☐ Negative ☐ Positive Sites _____

VRE: ☐ Negative ☐ Positive Sites _____

CDifficile: ☐ Negative ☐ Positive On Treatment: **Y N**

Associated Co-Morbidities

Diabetes ☐ Insulin dependant **Y N** ☐ Other _____

Mental Health

Depression	☐ Current	☐ Past History	☐ Actively Suicidal	☐ Hallucinations	☐ Delusions
Bipolar Disorder	☐ Current	☐ Past History	☐ Mania	☐ Depression	☐ Mixed Episode
	☐ With Hallucinations		☐ With Delusions		
Schizophrenia/Psychotic Disorder	☐ Current		☐ Past History	☐Hallucinations	☐ Delusions
Intellectual Disability	☐ Current		☐ Past History	☐ Suspected	☐ Confirmed
Dementia/Delirium	☐ Current		☐ Past History	☐ Suspected	☐ Confirmed

Psychiatrist Y N Name Phone

Addictions

Substance Use	☐ Current	☐ Past History		
Alcohol	☐ Yes	☐ No	Amount _____	Frequency _____
Cannabis	☐ Yes	☐ No	Amount _____	Frequency _____
Cocaine	☐ Yes	☐ No	Amount _____	Frequency _____
Opiates	☐ Yes	☐ No	Amount _____	Frequency _____
Other _____			Amount _____	Frequency _____
On Methadone	☐ Yes	☐ No		

If Yes, Treating Physician/Clinic _____

Phone _____

Is the individual expressing interest in addressing his/her current substance related abuse problem? ☐ Yes ☐ No

Behavioural

Criminal Charges	☐ Yes	☐ No
Violent Behaviour/Fire Starting	☐ Yes	☐ No
Suicide Attempts	☐ Yes	☐ No
Other Self-Harm Behaviour	☐ Yes	☐ No
History of Assaultive Behaviour	☐ Yes	☐ No

Special Needs

Oxygen: **Y N** If yes, @ _____ L/minute

IV/Saline Lock: **Y N** If yes, Date Inserted: _____

Special Diet: **Y N** If yes, Dietary Requirements: _____

_____

Wound Care: **Y N** If yes, Stage & Sites: _____

_____

Blood Sugar Monitoring: **Y N** If yes, _____X per_____

Dialysis: **Y N** If yes, Haemo_____ Peritoneal_____

If Haemo, Dialysis Runs: Location _____ Times_____

If Peritoneal, Type_____ Frequency_____

Tube Feeding

G-Tube: **Y N** If yes, Date Inserted: _____

J Tube **Y N** If yes, Date Inserted: _____

NG Tube **Y N** If yes, Date Inserted: _____

Tube Feeding Formula & Rate _____

_____

_____

Level of Nursing Care Required

☐ Independent ☐ Ambulatory, some assistance needed with ADL's

☐ Non-ambulatory, assistance needed with ADL's ☐ Bedridden, total care required

CPR

☐ Yes ☐ No

Functional Status

Cognition:	☐ Unimpaired	☐ Impaired			
Behaviour:	☐ Cooperative	☐ Disruptive	☐ Aggressive		
Speech:	☐ Adequate	☐ Aphasic	☐ Dysarthric		
Vision:	☐ Adequate	☐ Impaired	☐ Vision Aids	Type _____	
Hearing:	☐ Adequate	☐ Impaired	☐ Hearing Aids	Type _____	

Communication

Patient's First Language: _____

Patient's Command of English: ☐ Fluent ☐ Some ☐ None

Interpreter Required: **Y N** ☐ Always ☐ Complex Medical Info Only

Substitute Decision Maker

Treatment Decisions	**Y**	**N**	if yes	Name	Contact #
Personal Care other than Healthcare	**Y**	**N**	if yes	Name	Contact #
Financial/Property	**Y**	**N**	if yes	Name	Contact #

Copy of SDM documentation must accompany patient

Emergency Contact if other than SDM:

Name Phone:

Status in Canada

☐ Citizen ☐ Sponsored Immigrant ☐ Landed Immigrant ☐ Refugee Claimant

☐ Student Visa ☐ Work Visa ☐ Visitor Visa ☐ No status

Healthcare Benefits

OHIP: **Y N** **OHIP Number** _____

Interim Federal Health Program: **Y N** **If yes, Copy of IFHP Documents must accompany Patient**

No Health Care Benefits: **Y**

Registered With Public Health TB UP Program: **Y N**

Comments

Physician/Designate Signature:

Print name: **Date:** y/m/d

I, _____agree to my admission to West Park Healthcare Centre for assessment and/or medical management of Tuberculosis

Patient or Substitute Decision Maker Signature:

Print name: **Date:** y/m/d

Please Note:

- *Admissions Are Determined By Medical Acuity.*
- *You Will Be Notified By Telephone Of Your Referral Status.*
- *Please Ensure That A Typed Medical Update, A Typed Discharge Summary & A List Of Discharge Medications, Time of Last Dose, Preferably Computer Generated, Are Faxed To The **Attention of Sharon Stewart**, 24 Hours Prior To Admission.*
- *West Park Healthcare Centre's TB Service Accepts Admissions by 10:00 A.M. Monday Through Friday.*
- *Thank You For Your Referral.*