



**Inpatient Referral Form
Tuberculosis Service 2 East B**

Return by fax: 416-243-8397

Please complete this form in full and fax with required documentation to the attention of:

Admitting Department

Addressograph

Name of Patient

Current Location

Home Address

D.O.B

Phone

Required Documentation — *Incomplete Referrals Will Not Be Processed*

- | | |
|--|--|
| <input type="checkbox"/> Typed Medical History & Physical Report | <input type="checkbox"/> Current MAR |
| <input type="checkbox"/> All Consultant Reports | <input type="checkbox"/> All Blood Work |
| <input type="checkbox"/> All Public Health Lab Reports | <input type="checkbox"/> Results of All Investigations |
| <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Living with Immuno Compromised individuals or Young Children | <input type="checkbox"/> Overwhelming Disease |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Drug Resistance |
| <input type="checkbox"/> Shelter user | <input type="checkbox"/> Co-morbidities |
| <input type="checkbox"/> Section 22 | <input type="checkbox"/> Section 35 |
| | <input type="checkbox"/> Drug Toxicities |
| | <input type="checkbox"/> Positive smears |
| | <input type="checkbox"/> 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**

Private Health Insurance: **Y N** **If yes, Copy of Insurance Documents must accompany Patient**

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

Comments

Physician/Designate Signature:

Print name:

Date:

I, _____ agree to my admission to West Park Healthcare
(Print Patient Name)
Centre for assessment and/or medical management of Tuberculosis.

Patient or SDM Signature:

Print name SDM Name:

Date:

Please Note:

- West Park Healthcare Centre's TB Service accepts admissions by 10:00 a.m. Monday - Friday.
- Ensure a list of discharge medications and time of last dose, preferably computer generated, are sent to our Admitting Department.
- Admissions are determined by medical acuity.
- Please share West Park Healthcare Centre's Visitor Policy with applicant, the policy can be found on our main website
- For more information about the inpatient program please contact the unit Care Coordinator 416-243-3600 x 4626
- Thank you for your referral.