CONTINUING CARE ORDER (Includes Referral)

Client Name: _____

HCN: _____

DOB: _____

attach patient label

FAX TO:

☐ Western Zone: 1-866-246-4554 ☐ Eastern Zone: 902-563-3433
☐ Northern Zone: 1-866-682-8170 ☐ Central Zone: 902-455-3809

- **Please ensure this Form contains complete and accurate information. Incomplete forms may delay service.**
- **Client Information and Health Problems/Diagnosis sections must be completed.**
- **Use the Referral and/or Order sections as needed.**
- **Medication Reconciliation should be attached unless not indicated.**
- **Clients who are ambulatory will be directed to a clinic, where available, to receive nursing service. Please share CLINIC FIRST messaging with Clients as relevant.**

CLIENT INFORMATION

Client Name Last: _____ First: _____ Middle: _____

HCN: _____ DOB (YYYY/MM/DD): _____ Client Phone: _____

Gender: _____ Preferred Language: _____ Interpretation Required? ☐

Civic Address Street/Apt: _____ City: _____ Postal Code: _____

Service Address ☐ Same as Civic Street/Apt: _____ City: _____ Postal Code: _____

Primary Care Provider (if has): _____ Phone: _____ Fax: _____

REFERRAL

Complete section for initial referral to a Continuing Care service, not needed if Client is already receiving the service in question.

☐ Contact Client directly OR ☐ Contact person listed below
Contact Name: _____ Contact Phone: _____ Relationship to client: _____

If Client is in hospital, what hospital/unit? _____ Estimated Date of Discharge: (YYYY/MM/DD): _____ Community Pharmacy (If applicable): _____

☐ Yes ☐ No Client with capacity, or Substitute Decision Maker (SDM)/guardian, consents to the referral and sharing client's personal health information with other care providers in the circle of care as needed to provide service. (If client has an SDM, include SDM documents if available.)

Reason for Referral ☐ Nursing ☐ Home/Community Supports ☐ Palliative Support ☐ Adult Protection

Referral Source Name: _____ Phone: _____ Fax: _____

Date completed (YYYY/MM/DD): _____

HEALTH PROBLEMS/DIAGNOSIS

Allergies: _____

MD/NP/RN-AP ORDER

Attach Home Oxygen prescription forms seperately. Orders are subject to approval based on Continuing Care's Service Authorization Guidelines.

☐ Wound Care Type of wound: _____ Location: _____

Requested Start Date for Community Nursing: _____

MD/NP/RN-AP Signature: _____ Date: _____