Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

Please return this form to the South West CCAC via fax to: London: 519-472-4045 (for clients living in London/Middlesex and Elgin counties)
Stratford 519-273-2847 or toll free: 1-855-223-2847 (for clients living in Grey/Bruce, Huron, Oxford, Perth)

South West CCAC
Referral/Request for Assessment

This is a PDF Interactive form. You have the option to complete all or parts, electronically. When completed, please print and fax to CCAC.

Client's Name*: ____________________

Address*: ____________________

Postal code:__________

Phone number *: ____________________

Is client aware of referral? ☐ Yes ☐ No

CELL/Alternate CLIENT Ph. No.:__________

Alternate CONTACT Pers. Ph. No: __________

Date of Birth *d/m/y* __________

Health Card # *:

Version:

Significant Medical - Information/Symptoms

Communicable Diseases:

Diagnosis:

Surgical Procedure/Date *d/m/y* __________

Prognosis ☐ Improve ☐ Deteriorate ☐ Maintenance Diagnosis /Prognosis Discussed with Client ☐ Yes ☐ No

Allergies:

TREATMENT ORDERS:

☐ CCAC Assessment | ☐ CCP (Coordinated Care Plan) | Telehomecare ☐ COPD ☐ CHF

Other Treatment Orders:

Degree of Weight Bearing ☐ None ☐ Partial ☐ Full ☐Progression

TREATMENT ORDERS: WOUND CARE

Wound Dx: ☐ Maintenance ☐ Healable ☐ Non- healable

☐ **Wound Care:** Client's receiving service within South West region will be provided wound care according to South West CCAC Wound Care Management Program unless otherwise indicated.

Note: **1) Treatments will be taught and services reduced when appropriate**
2) Wound care orders outside of best practice may not be eligible for SW CCAC services
3) Wound care products may be substituted to a comparable product based on SW CCAC supply list

Compression Therapy requires ABPI measurements VLU ABPI_____ Date *d/m/y* __________

Referring Physician or Nurse Practitioner

Name (Print) **Signature:** **Telephone:**

Date: *d/m/y* __________

Family Physician Name (Print)____________________ ☐ or **Same as Referring Physician**

Form initiated by (if other than Referring Physician or Nurse Practitioner)

Date: *d/m/y* __________

Name (Print) __________ Position __________

Signature:__________ Telephone__________

* = mandatory fields. This form **must be signed and dated by the Referring Physician or Nurse Practitioner** at the time of referral, if treatment orders require such signature. Information entered by other than the physician must be signed and dated.