Head Office
141 Weber Street South
Waterloo ON N2J 2A9
Phone (Intake): 519 883 5500
Fax (Intake): 519 883 5550
Toll Free Phone: 1 888 883 3313

Name ______
Address ______
City ______ PC ______
Phone ______ DOB ______ DD/MM/YY
HCN ______ VC ______

Request for CCAC Services

☐ **Referral from Community:** Phone Intake, complete this form in full, fax to Intake (phone & fax listed above)

☐ **Referral from Hospital:** Contact CCAC office, identify hospital/unit/floor ______, refer to back of this form for phone and fax numbers of CCAC hospital offices

☐ The client or lawfully authorized substitute decision-maker has consented to this referral

☐ Please contact the person below (if not the client) for assessment purposes due to:

☐ Questions relating to client capacity ☐ Hearing difficulties ☐ Language difficulties

☐ Client preference ☐ Other ______

Contact Person ______ Relationship ______

Phone (H) ______ Phone (C) ______ Phone (W) ______

Primary Care Physician ______

Requested Service(s)

Wherever feasible, the client/ caregiver is taught the treatment protocol.

☐ Dietetics
☐ Nursing
☐ RRN (complete WW586)
☐ Palliative Nursing
☐ Occupational Therapy
☐ Personal Support Services
☐ Physiotherapy
☐ Social Work
☐ Speech Language Pathology

Primary Diagnosis ______ Date ______

Secondary Diagnosis ______

Surgical Procedure ______ Date ______

Current Medications:

Allergies ______ Special Diet ______

Reason for Referral:

Primary Language ______ WSIB Claim? ☐ Yes ☐ No

For parenteral and infusion therapy (i.e., medication, hydration), please complete form WW525

Medical Orders:

☐ Drain Care ______ ☐ Wound Care Best Practice Protocol

☐ Urinary Catheter Care: ☐ Irrigate with __ cc NS until clear ☐ Removal Date ______

☐ Reinsert if unable to void ☐Size ____ Fr Catheter ☐ Change indwelling catheter ☐ Monthly ☐ Q 3 months ☐ Other

Hospice Palliative Care (for individuals living with a life-threatening illness/diagnosis, at any age, requiring care for comfort, improving their quality of living, or relieving symptom management issues)

ESAS SCORES FROM LAST VISIT (10 equals worst possible for each symptom) **SYMPTOMS PRESENTING ON** ____/____/____

Pain ____ Fatigue ____ Nausea ____ Depression ____ Anxiety ____ Drowsiness ____ Appetite ____ Wellbeing ____ SOB ____

Is patient aware of this palliative referral? ☐ Yes ☐ No **Performance Score:** PPS ____ ☐ SRK (complete form WW094A)

☐ Palliative Physician (*Referral does not mean acceptance. MRP remains responsible. Case Manager (CM) will contact to clarify care required.*)

☐ Nurse Practitioner (*works collaboratively with MRP*) ☐ Spiritual Care Provider ☐ Community Support Services

Name (please print) ______ ☐ MD ☐ RN(EC) Phone# (Private) ______

Signature ______ Date ______ Physician Billing/CNO# ______

Document Category: Medical
Document Type: Medical Orders

CCAC Hospital Offices:

CMH CCAC, Cambridge	Phone (519) 621-2330 x 4290	Fax (519) 621-4446
GGH CCAC, Guelph	Phone (519) 837-6440 x 2862	Fax (519) 767-2965
GRH FHC CCAC, Kitchener	Phone (519) 749-4300 x 7133	Fax (519) 894-8372
GRH KWHC CCAC, Kitchener	Phone (519) 749-4300 x 2789	Fax (519) 743-9783
NWHC GMH CCAC, Fergus	Phone (519) 883-5500 (Intake)	Fax (519) 883-5550
NWHC LMH CCAC, Mount Forest	Phone (519) 883-5500 (Intake)	Fax (519) 883-5550
NWHC PDH CCAC, Palmerston	Phone (519) 883-5500 (Intake)	Fax (519) 883-5550
SJHC CCAC, Guelph	Phone (519) 824-6000 x 4366	Fax (519) 823-9960
SMGH CCAC, Kitchener	Phone (519) 749-6578 x 1186	Fax (519) 749-6800