



**Inpatient Referral Form
Tuberculosis Service/2 East B
Return by Fax: 416-243-3684**

Addressograph

**Please Complete This Form in Full and Fax With Required Documentation to the Attention of:
Sharon Stewart, Care Coordinator, Tel: 416-243-3600 ext 4054**

Required Documentation — *Incomplete Referrals Will Not Be Processed*

- | | |
|--|--|
| <input type="checkbox"/> Typed Medical History & Physical Report | <input type="checkbox"/> Current MARS |
| <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: _____

Contact Person: _____ **Phone:** _____

Nursing Unit: _____ **Phone:** _____

Family Physician: _____ **Phone:** _____

Reason for Referral (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Infectious & living with at risk individuals | <input type="checkbox"/> Overwhelming Disease |
| <input type="checkbox"/> Drug Resistance | <input type="checkbox"/> Drug Toxicities |
| <input type="checkbox"/> Co-morbidities | <input type="checkbox"/> Other |

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	If Yes , Site(s)	_____

Drug Allergies:

Infectious Status

HIV:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Pending	Test Date _____
Hep B:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive		
Hep C:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive		
MRSA:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	Sites	
VRE:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	Sites	_____
CDifficile:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	On Treatment:	Y N
Other Infectious Diseases:		Y N		
If Yes, Diagnosis & Precautions:	_____			

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: _____
G-Tube Formulae & Rate:		_____
J Tube	Y N	If yes, Date Inserted: _____
J Tube Formulae & Rate:		_____
NG Tube		If yes, Date Inserted: _____
NG Tube Formulae & Rate:		_____

Level of Nursing Care Required

- | | |
|---|--|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Ambulatory, some assistance needed with ADL's |
| <input type="checkbox"/> Non-ambulatory, assistance needed with ADL's | <input type="checkbox"/> Bedridden, total care required |

CPR

- Yes No

Functional Status

- | | | | | |
|------------|--------------------------------------|-------------------------------------|---------------------------------------|------------|
| Cognition: | <input type="checkbox"/> Impaired | <input type="checkbox"/> Unimpaired | | |
| Behaviour: | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Disruptive | <input type="checkbox"/> Aggressive | |
| Speech: | <input type="checkbox"/> Adequate | <input type="checkbox"/> Aphasic | <input type="checkbox"/> Dysarthric | |
| Vision: | <input type="checkbox"/> Adequate | <input type="checkbox"/> Impaired | <input type="checkbox"/> Vision Aids | Type _____ |
| Hearing: | <input type="checkbox"/> Adequate | <input type="checkbox"/> Impaired | <input type="checkbox"/> 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: **Y N**

If yes, Name _____ Phone: _____

Emergency Contact if other than SDM:

Name _____ Phone: _____

Status in Canada

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Refugee Claimant | <input type="checkbox"/> Sponsored Immigrant | <input type="checkbox"/> Landed Immigrant | |
| <input type="checkbox"/> Permanent Resident | <input type="checkbox"/> Citizen | <input type="checkbox"/> Visitor Visa | <input type="checkbox"/> Student Visa |

Healthcare Benefits

OHIP: **Y N**

Interim Federal Health Program: **Y N**

No Health Care Benefits: **Y N**

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

Comments:

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 From 9:00 A.M. To 2:00 P.M. Monday Through Friday.
- Thank You For Your Referral.