West Park HEALTHCARE CENTRE
Get your life back.

Inpatient Referral Form
Tuberculosis Service - 1D

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

Phone **D.O.B**

Required Documentation — *Incomplete Referrals Will Not Be Processed*

- ☐ Typed Medical History & Physical Report
- ☐ Current MAR
- ☐ All Consultant Reports
- ☐ All Blood Work
- ☐ All Public Health Lab Reports
- ☐ Results of All Investigations
- ☐ 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)

- ☐ Living with Immuno Compromised individuals or Young Children
- ☐ Overwhelming Disease
- ☐ Homeless
- ☐ Drug Resistance
- ☐ Drug Toxicities
- ☐ Shelter user
- ☐ Co-morbidities
- ☐ Positive smears
- ☐ Section 22
- ☐ Section 35
- ☐ 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 _____

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 dependent **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**

Social Information

Discharge Destination: _____

Discharge Plan Discussed With Patient/SDM: **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 Service Coordinator 416-243- 3600 x 34626**
- **Thank you for your referral.**