Manitoba

Department of Families

Date of Referral: _____

Community Nurse Consultant Service Referral Form

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the individual's health care intervention(s) and request Community Nurse Consultant Service (CNCS) support. Services may include the development of a health care plan and training delegation by a nurse for individuals supported by Community Living disABILITY Services as well as their service providers or support network. Completion of this form does not guarantee service. If you have questions about the information requested on this form, you may contact the program.

FAX COMPLETED FORM TO: 1-204-856-4258

Please ensure SECTION V–AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND CONSENT on Page 3 is signed.

Receipt of your referral will be confirmed to the contact person and CSW via email. A Nurse Consultant will endeavor to respond within 5 business days. For further information or enquiries, call CNCS at: 1-204-856-4218.

SECTION I – COMMUNITY PROGRAM INFORMATION

(to be completed by the individual making the referral-Primary Care Provider/CSW/Agency)

Type of community program (please x)

- ☐ Agency
- ☐ Home share
- ☐ Respite
- ☐ Recreation/Day program

Name of Community Program: _____

Contact Person: _____

Phone: _____ Fax: _____

Email: _____

CSW Name: _____

CSW Email Address: _____

Address (**location where service is to be delivered**):

Street: _____

City/Town: Postal Code:

SECTION II – CLIENT INFORMATION

Last Name	**First Name**	**Alias (Also Known as)**

DOB: Month	**Day**	**Year**	**Personal Health Information Number (9 Digit)**	**Family Physician**

SECTION III – TYPE OF SERVICE(S) or INTERVENTION(S) YOU ARE REQUESTING

(Please check (X) all that apply)

See Page 2 to indicate health issue(s) associated with service or intervention being requested:

☐ **Training – Client Specific**

(*Education delivered to specific Agency staff based on one client's needs (i.e. Individualized Health Care Plans/Delegations, etc.)*

☐ **Training – General Education to Agency Staff / Day Program Staff, etc.**

☐ **Clinical Intervention** *(i.e. health history review, medication education/administration, bowel/bladder management, diabetes, enteral feeding, G-Tube change, delegation hand-offs, etc.).* ***Describe below:***

_____

_____

☐ **Ongoing Health Monitoring** *(i.e. scheduled assessments, check-ins, attend planning meetings or medical appointments, bloodwork, etc.).* ***Describe below:***

_____

_____

☐ **Other** (*Please describe issue/need below):*

_____

_____

SECTION IV – HEALTH CARE ISSUE(S) or CONDITION(S)

Please check (x) all health care issues or conditions for which the individual requires an intervention:

*Note: further information required for issues/conditions with an *asterisk, please fill out additional information below*

☐ Allergy *	☐ Bladder *	☐ Blood Pressure	☐ Bloodwork	☐ Bowel Management *
☐ Cardiac *	☐ Catheter	☐ Check-Ins	☐ Diabetes *	☐ Drug Toxicity
☐ Edema	☐ Enteral Feeding *	☐ Epilepsy	☐ Eye Care	☐ Fluid Restriction
☐ G-Tube Change	☐ Hyponatremia	☐ Nutrition	☐ Ostomy *	☐ Primary Care Provider Appt
☐ PICA	☐ Respiratory *	☐ Scheduled Assessment	☐ Seizure *	☐ Skin Integrity
☐ Suctioning *	☐ Urinary Tract Infection	☐ Vasovagal	☐ Vital Signs	

☐ Other: _____ _____ _____ _____

_____ _____ _____ _____

Additional Information:

***Allergy** ☐ **Life-threatening allergy to:** _____

Do they utilize an EpiPen? ☐ YES ☐ NO

Do support staff require training/education to administer their medication? ☐ YES ☐ NO

***Bowel and Bladder management.** Please describe below:

_____

***Cardiac Condition** where the individual requires a specialized emergency response at the community program.

What type of cardiac condition has the individual been diagnosed with? _____

Do they require administration of Nitroglycerine spray? ☐ YES ☐ NO

***Diabetes**

What type of diabetes does the individual have? ☐ Type 1 ☐ Type 2

Do they require blood glucose monitoring? ☐ YES ☐ NO

Do they require assistance with blood glucose monitoring? ☐ YES ☐ NO

Do support staff require training with blood glucose monitoring/diabetes education? ☐ YES ☐ NO

***Enteral / Gastrostomy Feeding Care/Training/Delegation**

Do they require gastrostomy tube feeding? ☐ YES ☐ NO

Do they require administration of medication via the gastrostomy tube? ☐ YES ☐ NO

Do they have a written Care Plan for feeding and medication currently? ☐ YES ☐ NO

Do support staff require training and Delegation? ☐ YES ☐ NO

***Ostomy Care**

Do they require the ostomy pouch to be emptied? ☐ YES ☐ NO

Do they require the established appliance to be changed? ☐ YES ☐ NO

Do support staff require assistance/training with ostomy care? ☐ YES ☐ NO

***Respiratory**

Asthma (administration of medication by inhalation)

Can they take the asthma medication (puffer) on their own? ☐ YES ☐ NO

Do support staff require training to administer the medication? ☐ YES ☐ NO

Pre-set Oxygen

Do they require pre-set oxygen at the community program? ☐ YES ☐ NO

Do they bring oxygen equipment to the community program? ☐ YES ☐ NO

***Seizure Disorder:**

What type of seizure(s) does the individual have? _____

Does the individual require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

Do support staff require training? ☐ YES ☐ NO

***Suctioning (oral and/or nasal)**

Do they require oral and/or nasal suctioning? ☐ YES ☐ NO

Do support staff require assistance/training? ☐ YES ☐ NO

SECTION V–AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND CONSENT

I authorize Community Nurse Consultant Services serving Community Living disABILITY Services, all of whom may be providing services and/or supports to the individual, to exchange and release medical information specific to the health care interventions identified above and consult with the individual's primary care provider(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff

for _____ ***(Individuals Name-Please Print)***

I also authorize Community Nurse Consultant Services to include the individual's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about the individual will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the SDM/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

Questions about the use of the information provided on this form can be sent to the community program directly.

_____

Participant/SDM Name (please print or type)

_____ _____

Participant/SDM Signature Date