



Connecting you with care
Votre lien aux soins

CCAC **CCASC**

Community Care Access Centre
Centre d'accès aux soins communautaires

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 _____ <small>DD/MM/YY</small>
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 _____

<p>Requested Service(s)</p> <p>Wherever feasible, the client/caregiver is taught the treatment protocol.</p> <p><input type="checkbox"/> Dietetics</p> <p><input type="checkbox"/> Nursing</p> <p><input type="checkbox"/> Palliative Nursing</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Personal Support Services</p> <p><input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Social Work</p> <p><input type="checkbox"/> Speech Language Pathology</p>	<p>Primary Diagnosis _____ Date _____</p> <p>Secondary Diagnosis _____</p> <p>Surgical Procedure _____ Date _____</p> <p>Current Medications: _____</p>
	<p>Allergies _____ Special Diet _____</p> <p>Reason for Referral: _____</p>
	<p>Primary Language _____ WSIB Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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 _____ CPSO/CNO# _____

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