fraserhealth
Home Health Service Line
For health care and support at home
1.855.412.2121 **FAX.604.953.4966**

Physician/Nurse Practitioner Referral Form

Patient Information

Last name _____ First Name(s) _____

Address_____City _____Postal Code _____

Primary phone number _____ PHN _____

DOB _____ Gender ☐ M ☐ F

(d/m/y)

Alternative Contact

Best person to contact if patient not appropriate/available: _____

Phone number _____ Relationship _____

Reason to contact alternative ☐ Language ☐ Cognitive Impairment ☐ Hospitalized ☐ Other_____

Physician/Nurse Practitioner Referring Information

Name _____ MSP Billing number _____

Phone number _____ Fax number _____

Family GP/NP Name (**if different** from Referring Physician/NP) _____

Primary Reason(s) for Referral (check all that are being requested)

- ☐ Wound care (indicate type & frequency below)
- ☐ Complex medication regime **(requires orders attached)**
- ☐ Cognitive impairment concerns
- ☐ Caregiver fatigue
- ☐ Dietitian
- ☐ Not managing Activities of Daily Living
- ☐ Falling at home
- ☐ Mobility (transfer/ambulation)
- ☐ Support to manage Chronic Disease (home bound patients only)
- ☐ Palliative Care
  - ☐ Yes - MOST or No CPR document in place
  - ☐ Yes - Client on the BC PC Benefits Program
- ☐ Other (specify) _____

Provide specific details for referral including relevant diagnosis and orders (if required). Attach Patient's current medication list and "Problem list" if available.

Urgency of patient contact?

- ☐ High (within 1 – 2 days)
- ☐ Medium (within 3 – 5 days)
- ☐ Low (within 6 – 7 days)
- ☐ Pre arranging post procedure – **Pilonidal sinus and Fistulas only**

Type of Procedure planned _____

Date planned for procedure _____

Physician/Nurse Practitioner Signature_____

Date _____

FAX to Home Health Service Line (Central Intake) – 604-953-4966 or 1-855-953-4988

Questions regarding Referral – phone Home Health Service Line 1-855-412-2121

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