Department of Health & Seniors

YELLOW-Provider Copy / PINK- Patient Copy/ **WHITE**- Office Copy

Community Health Referral Form

Phone Referrals To: 292-3095 **Fax Form To:** 292-7627

E –Mail Referrals To: communityhealthnursing@gov.bm

Physiotherapy, Occupational Therapy, Speech & Language **Phone Referrals To:** 278- 6427 **Fax Form To:** 295-7636

Please fill out this form legibly and completely. Incomplete request may be returned and delay services					
Community Health Nurses have 48 hours to return phone calls to patients. Patients that require weekend services referrals should be sent to the Department of Health by 12 noon on Fridays or the day before a holiday.					
Reason for Referral: □ NURSING □ PERSONAL CARE □ NUTRITION □ PT □ OT □ SLP					
Patient Information					
LAST NAME:		FIRST NAME:			SEX: Male □ Female □
DOB Day Month Year		Age	Tel (H)		Tel (W)
Discharge Address:			**Parish:**		
Patient Contact Person			**Tel (H)**		**Tel (W)**
Family Physician			Consultant		
Medical Information					
Diagnosis:					
Surgical Procedures:					
Allergies: □ Drug □ Food □ Other			Reactions:		
Supplies / Equipment: □ Cane □ Wheelchair □ Walker □ Prosthesis □ Dressing □ Other					
Activities Permitted: □ Bedrest □ Wheelchair □Transferable (Bed/Chair) □ Partial weight bearing □ Walker □ Cane □ Crutches □ No Restrictions					
Physicians orders : Please attach prescription sheet as well as a list of current medication(s)					
Nutrition: Diet:				Height:	Weight:
Treatments/services					
□ Dressing : Type:					Frequency:
□ Sutures Removal Date:		□ Clips/Staples		Remove on date:	
□ Monitor Blood Pressure	Frequency:		□ Monitor Blood Sugar		Frequency:
□ Medication Administered	□ Medication Preload		□ Catheter Care		□ Patient Education
□ Other services involved □ Meals on Wheels □ PALS □ Home Care □ Other					
N.B All required supplies and equipment for homecare services must be provided by client					

Follow up appointments: □ Fracture Clinic / / □ Diabetes Education / / □ Physicians / /

Other_____ Referred from (Indicate Department) _____

Name/Title (Print) _____ Signature_____

Patient Consent (Signature) _____ Discharge Date _____

***All referrals must have a discharge summary attached. From GP's office a history of the patient must be attached.**

Does patient have history of: □ Violence □ ETOH Abuse □ Substance Abuse □ Mental Health Status

Does patient live alone? □ No □ Yes: How many____

Any concerns of pets in the home?

Additional Comments:

Revised August 27, 2019