Pediatric Home & Community Care

Our aim at CHEO is to provide a more integrated system of care to families of children and youth with special needs — one that focuses on children's individual needs and provides a smooth transition between services at CHEO, at home and in the community. CHEO's Home and Community Care program provides pediatric home and community care services in the Champlain region.

Pediatric Home & Community Care (HCC)

Our patient care coordination teams help develop care plans, to ensure safe and high-quality care aimed at keeping patients healthy and in their homes. CHEO delivers the following pediatric services, in the home and community, in partnership with trusted partners:

- Nursing (wound care, medication administration, IV access, ostomy care, catheter care)
- Rapid Response Nursing
- Personal support services
- Physiotherapy
- Occupational therapy
- Nutritional counseling

Please consult our website for detailed information about each service.

Children and youth also receive School-Based Rehabilitation Services, which includes:

- Occupational Therapy
- Physiotherapy
- Speech-language Pathology: a recent (<12months) SLP evaluation report is required.

Referrals for school therapy services are made by the child's school. CHEO partners with CommuniCare to deliver services in Ottawa, North Lanark/North Grenville (NLNG), and parts of Eastern Counties. CHEO therapists provide services in Renfrew County and parts of Eastern Counties.

Quick tips for efficient referrals to HCC

- Please ensure a primary contact has been identified and their contact details are provided.
- Please indicate if an interpreter will be required and for which language. This assists us to complete our intake assessment in a timely manner.
- For same day requests, referral must be sent, at minimum before noon.
- For Infusion Therapy requests, please ensure *all* the following information is included on the referral:
    - Line type: PICC, indwelling catheter, Peripheral Intravenous Catheter
        - For PICC: include PICC type, size, lumen, external length
    - Last dressing change date (for PICC care and wounds), and when next change is due
    - Medication *name*, *dose*, *route*, *frequency,* time *first dose* given, and medication *stop date.*

2. Please ensure your contact details are provided.

The Intake Care Coordinators will contact you only if they have any follow up questions that are pertinent to the referral.

The Integrated Care Deliver program has a *Nursing Clinic first* philosophy, where all request for nursing are first sent to clinics (within 25 kms of the patient's house).

For more information and/or eligibility criteria, you can contact us every day including weekends and holidays, 8am-8pm, at 613-737-7600 x1794 or by email: integratedcaredelivery@cheo.on.ca. We respond to emails within 1-2 business days. Email should not be used for urgent or sensitive communication. Do not send personal health information via email.

Referral to Pediatric Home & Community Care

Confidential. If you have received this form in error, please contact 613-737-7600 x1794

Estimated Date of Discharge (EDD): (if applicable)		
Patient Details and Demographics		
Health card #: VC: ☐No VC		
Surname:	Given Name(s): Preferred Name:	
Home Address: ☐No Known Address		City:
Postal Code: Tel#: Alternate Tel#:		
Address for treatment: (Complete if different from Home Address)		City:
Postal Code: Tel#: Alternate Tel#:		
Date of birth:	Gender: ☐Male ☐Female ☐Non-Binary Pronouns: ☐He/Him ☐She/Her ☐They/Them	
Primary Language: ☐English ☐French ☐Other: Preferred Language for Service: ☐English ☐French Interpreter Required: ☐Yes ☐No		
Name of Primary Contact Person (leave blank if patient is the primary contact): Relationship: ☐Parent ☐Grandparent ☐Sibling ☐Other: _____ Tel#: Alternate Tel#:		
Name of Secondary Contact Person (leave blank if patient is the primary contact): Relationship: ☐Parent ☐Grandparent ☐Sibling ☐Other: _____ Tel#: Alternate Tel#:		
Detailed Health Information		
Precautions: ☐Routine ☐Droplet ☐Contact ☐Airborne Infective Organism:		
Allergies: ☐NKA ☐Yes----if Yes, List Allergies:		
Primary Diagnosis		
Secondary Diagnosis		
Reason for Referral		
Relevant Medical History		
Surgical or other procedures		
Medication	☐ see additional list (attached)	
Diet		
Community Health Care Provider (e.g., MD or NP) ☐None	Surname:	Given Name(s):
Additional documentation attached to referral? ☐Yes ☐No		

Surname:	HCN:
Given name:	VC:

Referral to Pediatric Home & Community Care

Confidential. If you have received this form in error, please contact 613-737-7600 x1794

Services Requested

☐Clinical Nutrition ☐Nursing ☐Occupational Therapy

☐Personal Support/Care ☐Physiotherapy ☐Rapid Response Nurse (RRN) ☐Speech Therapy

Please complete all the following sections as appropriate. Incomplete medical orders cannot be processed and will delay initiation of services

IV ACCESS & CARE:

PICC Type: _____Size: _____Lumen: _____ External Length: _____

☐Tunneled Cuffed (Broviac®) ☐Totally Implanted Device (Port) ☐Peripheral Last Dressing Change

MEDICATION: (IV & SC to be administered by home care)

Patient's Weight: _____kg

1_____Dose: _____Route: ____Freq: ____ Stop Date/Time

2_____Dose: _____Route: ____Freq: _____Stop Date/Time

First dose date & time: _____

Date and Time of last IV dosage in Hospital: _____

Heparin Locking: ☐No ☐Yes---If Yes, **Concentration: _____Dose: _____ Freq: _____**

If unable to restart IV, client must: ☐Go to ED ☐Miss / delay dose ☐Take PO or IM (give prescription to client)

Section 8 required? ☐No ☐Yes ---- Code _____

WOUNDS: (as per www.RNAO.ca best practice)

Type: _____

Cleanse: ☐ Normal saline ☐Sterile water

Frequency: _____ Follow Up Appointment:

Apply/Cover (supplies): _____

Orders: _____

OSTOMY CARE: Type _____	**CATHETER CARE:** Type: _____Size: _____
Orders:	Frequency: _____

FEEDINGS:

☐NG ☐NJ Size: _____ External Length_____ ☐GTube ☐GJ Size: _____

Formula: _____ Orders (e.g., rate, duration): _____

RESPITE:

Enhanced Respite for Medically Fragile and/or Technology Dependent Children Program Funding:

Referring Physician/NP/Organization Information & Signature of Referral Source

Organization/Unit:	Tel#:	Fax#:
Name:		Date:
Signature:		CPSO#:

For more information and eligibility criteria, please contact us at 613-737-7600 x1794 or by email integratedcaredelivery@cheo.on.ca

Please send referral to fax #613-745-1732

The personal information and personal health information collected in this referral form is used to determine eligibility for admission to Integrated Care Delivery services. By submitting this information, you are consenting to CHEO to use, share, collect and disclosure of your and your child's personal health information for the purpose of Integrated Home and Community Care services. This information will be part of the child/youth's medical record and is kept secure and confidential. For more information about consent and our privacy practices, contact the CHEO Privacy Team at privacy@cheo.on.ca