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| **Date of Referral:**       |
| **REFERRAL FROM A PHYSICIAN IS REQUIRED** |
| Nursing Support Services provides planned, intermittent periods of respite for parents/guardians of medically complex and fragile children/youth (0 – 19) in their home communities whose care requires the knowledge, judgment and skill of a registered nurse in the absence of the parent/guardian**.** |
| **ELIGIBILITY FOR SERVICES REQUIRES ALL OF THE FOLLOWING:** |
|  Child/youth is a resident of BC as defined by BC Medical Services Plan (MSP) Child/youth is enrolled with BC’s MSP Child/youth is under the age of 19 (up to the day of their 19th birthday) Child/youth requires regional and/or provincial subspecialty health services[[1]](#footnote-1) Child/youth requires in home care within the scope of practice of a registered nurse due to their high  complexity health needs Child/youth is not in receipt of a settlement or court award related to their disability Referral from a physician licensed to practice in British Columbia or a nurse practitioner registered by the College of Registered Nurses of British Columbia and who confirms the following: the child/youth can be safely discharged to and cared for in the specified community setting the child/youth has a local physician to provide required medical care, consultation and written physician orders the parent or guardian has overall responsibility of their child/youth’s care and is fully competent and prepared to provide care in the absence of a nurse |
| Is the parent/guardian aware of and has provided consent for this referral? Yes NoIf no, please obtain consent prior to submission of referral. |
| Is an interpreter required? Yes NoIf yes, what language(s)? |
| **CHILD/YOUTH INFORMATION** |
| NAME OF CHILD           | GENDER[ ]  M [ ]  F | PERSONAL HEALTH NUMBER           | DATE OF BIRTH (YYYY/MM/DD)           |
| NAME OF PARENT(S)/GUARDIAN(S)      | DAYTIME PHONE NUMBER      | EVENING PHONE NUMBER      |
| ADDRESS           | CITY           | POSTAL CODE           |
| **List all known medical diagnoses:**   | *
 |
| **Significant medical history:***A letter may be attached to include all relevant details*  | *
 |
| **PRIMARY CARE NEEDS (check and complete all that apply)** |
| **Respiratory Care** |
| **Tracheostomy** *(please detail care requirements and frequency):*  |        |
| **Ventilation**  | [ ] N/A [ ]  Continuous [ ]  Night time/naps [ ]  Time Periods off ventilator *(please describe)*:            |
| **BiPAP** | [ ] N/A [ ]  Required/life-sustaining [ ]  As tolerated [ ]  Night time/naps [ ]  nasal mask [ ]  face mask [ ]  Time Periods off BiPAP *( please describe):*           |
| **CPAP** | [ ] N/A [ ]  Required/life-sustaining [ ]  As tolerated [ ]  Night time/naps [ ]  nasal mask [ ]  face mask [ ]  Time Periods off CPAP *(please describe):*           |
| **Oxygen Management** | [ ] N/A [ ]  Continuous [ ]  Night time/naps [ ]  Time Periods off oxygen [ ]  Titration required? *(please describe):*            |
| **Suctioning** | [ ] N/A [ ]  oral only [ ]  pharyngeal [ ]  nasal [ ]  frequency *(please describe)*:            |
| **Complex Airway Management** *(please detail care requirements and frequency):*  |           |
| **Parent Education Progressing**:  | ☐Y ☐N Comments: |          |  |
| **Palliative Care** *(completed signed BC Palliative Care Benefits Registration is required)* |  |
| **Palliative care management** (*describe the nature and frequency of care*):  |           |  |
| If palliative, is there an expected death in home plan?       |  |
| **Peritoneal Dialysis** |  |
| **Peritoneal dialysis management** (*describe the nature and frequency of care*):  |            |  |
| **Total Parenteral Nutrition** |  |
| **Total Parenteral Nutrition Management** (*describe the nature and frequency of care*):  |            |  |
| **Complex feeding (NG/NJ, refeeding)** |  |
| **Complex feeding care management** (*describe the nature and frequency of care*):  |           |  |
| **Other complicating risk factors** (*describe the nature and frequency of care*):  |           |  |
| **Other care needs that require the scope of a registered nurse** |  |
| **Care needs** *(describe the nature and frequency of care):* |           |  |
| **Target discharge/transition date**  |            | **Hospital/unit:** |            |  |
| **PHYSICIAN INFORMATION** |  |
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| REFERRING PHYSICIAN NAME           | BC MSC#                |
| ARE YOU A:[x] pediatrician [x]  family practitioner [ ]  other medical specialist *(describe)*       |
| ADDRESS      | PHONE NUMBER      | FAX NUMBER      |

 |  |
| **Physician signature *(required)*:**  |       | **Date completed (YYYY/MM/DD):**  |            |  |
| ***Please attach recent consultations and notes for our review to assist in determining eligibility for services.******Completed referral forms and accompanying documentation may be sent via E-mail to nssreferrals@cw.bc.ca or fax: 604.708.2127 or 604.453.8397*** |  |
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1. http://www.childhealthbc.ca/sites/default/files/17%2004%2001%20Fact%20Sheet%201%20TOS%20Overview\_0.pdf [↑](#footnote-ref-1)