|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 No  If no, please obtain consent prior to submission of referral. | | | | | | | | | | | | |
| Is an interpreter required? Yes No  If 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** | | | | | | | | | | | | |  |
| |  |  |  |  | | --- | --- | --- | --- | | REFERRING PHYSICIAN NAME | | BC MSC# | | | ARE YOU A:  pediatrician  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)