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| **Date of Referral:** | | | |
| **REFERRAL FROM A PHYSICIAN/PRIMARY HEALTH CARE PROVIDER IS REQUIRED** | | | | | | | | | | | |
| Nursing Support Services provides care in the school setting for children (0 – 19) who require assistance with specific tasks related to their care. Delegation of these tasks is determined by the registered nurse on an individual basis for children/youth whose care needs and response to treatment is stable and predictable and can be safely managed by NSS provincial standardised care plans. | | | | | | | | | | | |
| **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 has a parent/guardian that has overall responsibility of their child/youth’s care and is fully competent and prepared  to provide care in the absence of school staff  Child/youth cannot independently and safely perform tasks related to their diagnosis  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 cared for in the school setting  the child/youth has a local physician to provide required medical care, consultation and written  physician orders | | | | | | | | | | | |
| 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 |
| Name of School and District: | | | | | Teacher:       grade: | | | | | | |
| **List all known medical diagnoses and significant medical history:**  *A letter may be attached to include all relevant details* | | | | |  | | | | | | |
| **Current health care needs for the school setting:**  *A letter may be attached to include all relevant details* | | | | |  | | | | | | |
| **REASON FOR REFERRAL (check and complete all that apply)** | | | | | | | | | | | |
| **Seizure care** *(please detail care requirements and frequency)*  *If child has rescue medications please see page 3 of this form* |  | | | | | | | | | | |
| **Tube meals**  *(please detail care requirements and frequency):* |  | | | | | | | | | | |
| **Suctioning**  *(please detail care requirements and frequency):* |  | | | | | | | | | | |
| **Intermittent Catheterization**  *(please detail care requirements and frequency):* |  | | | | | | | | | | |
| **Other**  *(please detail care requirements and frequency):* |  | | | | | | | | | | |
| **Other Agencies/ Persons Involved in Child’s Care** | | | | | | | | | | | |
| **Name, position, contact information:** |  | | | | | | | | | | |
| **Name, position, contact information:** |  | |  | | | | | | | | |  |
| **Name, position, contact information:** |  | |  | | | | | | | | |  |
| **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 (nssreferrals@cw.bc.ca) or fax to 604.708.2127 or 604.453.8397*** | | | | | | | | | | | |  |
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**Medication Administration Form**

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| **TO BE COMPLETED BY PARENT OR GUARDIAN** | | |
| NAME OF CHILD | | BIRTH DATE (YYYY/MM/DD) |
| NAME OF PARENT/GUARDIAN | HOME PHONE NUMBER | WORK PHONE NUMBER |
| **TO BE COMPLETED BY PRESCRIBING PHYSICIAN** | | |
| CONDITION(S) REQUIRING MEDICATION: | | |
|  | | |

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| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Frequency** | **Route** | **Specific Directions for Use** |
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| ADDITIONAL COMMENTS/POSSIBLE REACTIONS/CONSEQUENCES OF MISSING MEDICATION: (USE BACK OF FORM IF MORE SPACE IS REQUIRED) |
|  |

Name of Physician (please print) Signature of Physician Date Signed (YYYY/MM/DD) Phone Number

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| --- | --- |
| To Be Completed By Parent Or Guardian  I request the school/child care to give the medication as prescribed in Section B of this form to my child named in Section A of this form | To Be Completed By registered Nurse After The Completed Request Is Returned To The School/Child Care  Comments: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of Parent or Guardian |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature of Parent or Guardian |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Date Signed (YY/MM/DD) | Signature of Registered Nurse Date Signed (YY/MM/DD) |

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| **EACH TRAINED CAREGIVER RESPONSIBLE FOR ADMINISTERING OR SUPERVISING OF SELF ADMINISTRATION OF MEDICATION** | | |
| Name of Trained Caregiver | Signature | Date Signed (YYYY/MM/DD) |
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