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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 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           |
| 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** |  |
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| --- | --- |
| 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 GuardianI 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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