North East CCAC / CASC
Community Care Access Centre — Centre d'accès aux soins communautaires du Nord-Est

Referral for NE CCAC Services

Surname: _____ First Name: _____

CCAC Client #: _____ Date of Birth (DD/MM/YYYY): _____

HCN: _____ Version Code: _____

☐ **Client agreeable to referral to CCAC.**	Diagnosis:
Address:	P.O. Box:
Town/City:	Postal Code:
Phone (Home): (Work):	Phone (Cell):
Prognosis: ☐Improve ☐Remain Stable ☐Deteriorate ☐End of Life-PPS:____ ☐ DNR in place Oncology Patient: ☐No ☐Yes – Cancer type/staging: _____ Treatment: ☐Curative ☐Palliative	
Surgical Procedure: Date: _____ (DD/MM/YYYY)	Planned Hospital Discharge Date: _____ (DD/MM/YYYY)
Allergies:	

Services Requested:	**Specific Orders/Request:**	
☐ Nursing		☐Symptom Relief Kit *(where applicable)*
☐ Personal Support		
☐ Physiotherapy		☐ Full-weight bearing ☐ Non-weight bearing ☐ Partial-weight bearing
☐ Occupational Therapy		
☐ Social Work		
☐ Speech-Language Pathology		
☐ Nutrition		
☐ Enterostomal Therapist		
☐ Telehomecare Nursing		
☐ Rapid Response Nursing	☐ where applicable	
☐ Nurse Practitioner *Primary Care*	☐ Sudbury ☐ North Bay ☐ Sault Ste. Marie	
☐ Nurse Practitioner *Palliative Care (<12 months)*	☐ Sudbury ☐ West Nipissing ☐ Sault Ste. Marie ☐ Timmins ☐ Kirkland Lake	

IV INFUSION ORDER : ☐ **Central Line** **Type:** _____ ☐ **Peripheral Line**

***Radiologic report confirming PICC line placement must accompany the referral.**

Drug _____ Dose: _____	Drug _____ Dose: _____
Frequency: _____	Frequency: _____
Date/Time Initial Dose Given: _____	**Date/Time Initial Dose Given:** _____
Next Dose Due: _____	Next Dose Due: _____
Number of Doses to be Given: _____	Number of Doses to be Given: _____

FLUSH INSTRUCTIONS: ☐ **PER local protocol** *Site care shall be done per CVAA (Canadian Vascular Access Association) Best Practice Guidelines.*

OR

☐ Normal Saline _____ ml ☐ Peripheral 5ml normal saline

☐ Heparin 100u/ml _____ ml ☐ Central Line (CVAD) 10-20 ml _____

As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue the treatments when applicable.

Referring Party Name/Designation (Print):

Referring Party Signature: Date (DD/MM/YYYY):

Please provide the most current medication list upon referral to the NE CCAC.

☐ **KIRKLAND LAKE BRANCH**	☐ **NORTH BAY BRANCH**	☐ **PARRY SOUND BRANCH**	☐ **SAULT STE. MARIE BRANCH**	☐ **SUDBURY BRANCH**	☐ **TIMMINS BRANCH**
53 Government Road W. Kirkland Lake ON P2N 2E5	1164 Devonshire Ave. North Bay ON P1B 6X7	70 Joseph St. Unit 105/106 Parry Sound ON P2A 2G5	390 Bay St., 2nd Floor Sault Ste. Marie ON P6A 1X2	40 Elm St., Suite 41-C Sudbury ON P3C 1S8	330 Second Ave., Suite 101 Timmins ON P4N 8A4
Tel: 705 567 2222 888 602 2222	Tel: 705 476 2222 888 533 2222	Tel: 705 773 4602 800 440 6762	Tel: 705 949 1650 800 668 7705	Tel: 705 522 3461 800 461 2919	Tel: 705 267 7766 888 668 2222
Fax: 705 567 9407	Fax: 705 474 0080	Fax: 705 773 4056	Fax: 705 949 1663	Fax: 705 522-3855	Fax: 705 360 5554