Manitoba
Department of Families

Community Nurse Consultant Service Referral Form

In accordance with Section 15 of The Personal Health Information Act (PHIA), the purpose of this form is to identify the individual's health care intervention(s) and request Community Nurse Consultant Service (CNCS) support. Services may include the development of a health care plan and training delegation by a nurse for individuals supported by Community Living disABILITY Services as well as their service providers or support network. If you have questions about the information requested on this form, you may contact the program.

Section I – Community program information (to be completed by the individual making the referral- Primary care provider/CSW/Agency)

Type of community program (please √)

- ☐ Agency
- ☐ Home share
- ☐ Respite
- ☐ Recreation/Day program

Name of community program:

Contact person:

Phone: Fax:

Email:

Address (**location where service is to be delivered**):

Street:

City/Town: Postal Code:

Section II - Client information

Last Name **First Name** **Birthdate**

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the individual requires an intervention.

☐ **Individualized Health Care Plan**

☐ **Medication review/administration/education**

☐ **Health History review and consultation to attend interdisciplinary planning meetings/medical appointments related to the individual. Please describe below:**

☐ **On-going Health Monitoring for medically complex individuals. Please describe below:**

☐ **Bowel and Bladder management/education/training. Please describe below:**

☐ **Life-threatening allergy to:**

Do they utilize an EpiPen ? ☐ YES ☐ NO

Do support staff require training/education to administer their medication? ☐ YES ☐ NO

☐ **Asthma (administration of medication by inhalation)**

Can they take the asthma medication (puffer) on their own? ☐ YES ☐ NO

Do support staff require training to administer the medication? ☐ YES ☐ NO

☐ **Seizure Disorder:**

What type of seizure(s) does the individual have? _____

Does the individual require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

Do support staff require training? ☐ YES ☐ NO

☐ **Diabetes**

What type of diabetes does the individual have? ☐ Type 1 ☐ Type 2

Do they require blood glucose monitoring? ☐ YES ☐ NO

Do they require assistance with blood glucose monitoring? ☐ YES ☐ NO

Do support staff require training with blood glucose monitoring/diabetes education? ☐ YES ☐ NO

☐ **Cardiac Condition** where the individual requires a specialized emergency response at the community program.

What type of cardiac condition has the individual been diagnosed with? _____

Do they require administration of Nitroglycerine spray? ☐ YES ☐ NO

☐ **Gastrostomy Feeding Care/Training/Delegation**

Do they require gastrostomy tube feeding? ☐ YES ☐ NO

Do they require administration of medication via the gastrostomy tube? ☐ YES ☐ NO

Do they have a written Care Plan for feeding and medication currently? ☐ YES ☐ NO

Do support staff require training and Delegation? ☐ YES ☐ NO

☐ **Ostomy Care**

Do they require the ostomy pouch to be emptied? ☐ YES ☐ NO

Do they require the established appliance to be changed? ☐ YES ☐ NO

Do support staff require assistance/training with ostomy care? ☐ YES ☐ NO

☐ **Pre-set Oxygen**

Do they require pre-set oxygen at the community program? ☐ YES ☐ NO

Do they bring oxygen equipment to the community program? ☐ YES ☐ NO

☐ **Suctioning (oral and/or nasal)**

Do they require oral and/or nasal suctioning? ☐ YES ☐ NO

Do support staff require assistance/training? ☐ YES ☐ NO

Section III - Authorization for the Release of Medical Information and Consent

I authorize Community Nurse Consultant Services serving Community Living disABILITY Services, all of whom may be providing services and/or supports to the individual, to exchange and release medical information specific to the health care interventions identified above and consult with the individual's physician(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for _____ (Individuals name). I also authorize Community Nurse Consultant Services to include the individual's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that personal and personal health information will be kept confidential and protected in accordance with The Freedom of Information and Protection of Privacy Act (FIPPA) and The Personal Health Information Act (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about the individual will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the SDM/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

Questions about the use of the information provided on this form can be sent to the community program directly.

_____ _____

Participant/SDM Signature Date

_____ _____ _____

Mailing Address Postal Code Phone Number