Manitoba Home Nutrition Program

Referral Form - Adults

Lower Level - 425 Elgin Avenue
Winnipeg, MB, R3A 1P2
Phone: 204-940-1911 Fax: 204-940-1933

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

SECTION A

CLIENT INFORMATION

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Address: ______ City: ______ Postal Code: ☐☐☐☐☐☐

Contact Someone Other than Client: ☐ No ☐ Yes, if yes provide contact info:

Name: ______ Phone: ☐☐☐-☐☐☐-☐☐☐☐

Expected Duration of Nutrition Support: ______

Planned Discharge Date (if in hospital): D D M M M Y Y Y Y

Referring Prescriber: ______

Primary Care Physician and Address: ______

Relevant Diagnosis: ______

Relevant Medical & Surgical History: ______

Allergies: ______

Other Services Consulted: ☐ Home Care ☐ Palliative Care ☐ Long Term Care ☐ Social Work

Antibiotic Resistant Organisms (ARO):

MRSA: ☐ No ☐ Yes VRE: ☐ No ☐ Yes ☐ Other (specify): ______

Funding: ☐ Non-Insured Health Benefits ☐ Employment and Income Assistance
☐ Other: ______

SECTION B

TYPE OF FEEDING TUBE *(Mark an X in applicable box)*

☐ PEG (non-balloon GT) ☐ Balloon GT ☐ Jejunostomy ☐ Nasogastric ☐ Nasojejunal

Brand Name: ______ Size: ______

Insertion Date: D D M M M Y Y Y Y Physician: ______

CURRENT TUBE FEED REGIME *(Mark an X in applicable box)*

☐ Gravity ☐ Pump ☐ Syringe

Formula, Amount & Frequency: ______

Water Flushes: ______

SECTION C

CENTRAL VENOUS ACCESS DEVICE *(Mark an X in applicable boxes)*

☐ Tunnelled Central Line ☐ Port-A-Cath ☐ PICC

Brand Name: ______ Size: ______

☐ Single Lumen ☐ Double Lumen ☐ Triple Lumen

Insertion Date: D D M M M Y Y Y Y Inserted by Physician/Nurse: ______
PRINTED NAME

Winnipeg Regional Health Authority — Caring for Health
Office régional de la santé de Winnipeg — À l'écoute de notre santé

Manitoba Home Nutrition Program

Referral Form - Adults

Lower Level - 425 Elgin Avenue
Winnipeg, MB, R3A 1P2
Phone: 204-940-1911 Fax: 204-940-1933

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

SECTION D

EDUCATION

Who will be taught? ☐ Client ☐ Caregiver ☐ Other: ______

Interpreter required? ☐ No ☐ Yes, specify: ______

Variables affecting client learning:

☐ Ambulation ☐ Cognition ☐ Dexterity ☐ Hearing ☐ Speech ☐ Vision ☐ Other: ______

Describe Variables: ______

Names and Phone Numbers of Learners (MHNP only trains primary caregivers [i.e. family/friend]):

______ ___-___-____ ______ ___-___-____

______ ___-___-____ ______ ___-___-____

MHNP *TUBE FEEDING* REFERRAL CHECKLIST *the following must be sent with the referral:*

- ☐ Completed Sections A, B & D
- ☐ Nutrition Assessment: Acute Care
- ☐ Medication list with type, dosage, route & frequency
- ☐ Tube insertion report (if available)
- ☐ Speech Language Pathologist Assessment (if applicable)

MHNP *TPN REFERRAL* CHECKLIST *the following must be sent with the referral:*

- ☐ Completed Sections A, C & D (include section B if applicable)
- ☐ Nutrition Assessment: Acute Care
- ☐ Medication list with type, dosage, route & frequency
- ☐ Present TPN Prescription including rate & hours of infusion
- ☐ Recent blood work results including all of the following:
- ☐ CBC, PT/INR, NA, K, Cl, G, U, CR, CA, P, MG, TP, AL, CH, TG, ALK PHOS, ALT, AST, TB, DB, iron, ferritin, PALB, vitamin D25, ZN, copper
- ☐ Report of central line insertion
- ☐ Chest X-ray identifying central venous access device tip location

MHNP *HYDRATION* REFERRAL CHECKLIST *the following must be sent with the referral:*

- ☐ Completed sections A, C & D
- ☐ Report of central line insertion
- ☐ Chest X-ray identifying central venous access device tip location
- ☐ Present Hydration Prescription including rate and hours of infusion

Completed by:

______ Signature ______ Printed Name & Designation Date: D D M M M Y Y Y Y

LEGEND:

AL - Albumin
ALK PHOS - Alkaline Phosphatase
ALT - Alanine aminotransferase
AST - Aspartate Aminotransferase
CA - Calcium
CBC - Complete Blood Count
CH - Cholesterol
Cl - Chloride
CR - Creatinine
DB - Bilirubin, Direct
G - Glucose
GT - Gastrostomy Tube
PT/INR - Prothrombin/International normalized ratio
K - Potassium
MG - Magnesium
MHNP - Manitoba Home Nutrition Program
MRSA - Methicillin Resistant Staphylococcus Aureus
NA - Sodium
P - Phosphate
PALB - Prealbumin
PEG - Percutaneous Endoscopic Gastrostomy
PICC - Peripherally Inserted Central Catheter
TB - Bilirubin, Total
TG - Triglycerides
TP - Total Protein
TPN - Total Parenteral Nutrition
U - Urea
VRE - Vancomycin Resistant Enterococci
ZN - Zinc