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

ANTENATAL HOME CARE PROGRAM REFERRAL FORM

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address (home visits only)

Call prior to faxing referral to confirm program availability and ensure program criteria are met.
Antenatal Home Care Program Phone 204-792-5463 or 204-940-2164 Fax 204-940-2189

Referral source: Referral discussed with client ☐ Yes ☐ No

☐ Triage/Perinatal Assessment Unit: Date Seen: D D M M M Y Y Y Y

☐ Physician Office: Date Seen: D D M M M Y Y Y Y Physician Name: _____

☐ Hospital: ☐ St. Boniface ☐ Women's Centre Date Admitted: D D M M M Y Y Y Y Date Discharged: D D M M M Y Y Y Y

☐ Other: _____

Address: _____

Home Phone: ___-___-___ Cell Phone: ___-___-___

Gravida: ____ Parity: ____ Gestation: ____ weeks Estimated Date of Confinement: D D M M M Y Y Y Y

Diagnosis: ☐ Hypertension ☐ Threatened Preterm Labour ☐ Preterm Premature Rupture of Membranes ☐ Other: _____

Assessment/Condition Summary: *(include vital signs, symptoms of condition, associated medical conditions)*

_____

_____

_____

Lab done: ☐ Yes ☐ No If Yes, Date Done: D D M M M Y Y Y Y

Blood Pressure Cuff Size: ☐ Regular ☐ Large **Weight:** _____ kg

Current Medication(s) and Dose/Timing: _____

Accompanying Documentation required: *(if available)*

☐ Medication Reconciliation Form ☐ Most Recent Lab Results ☐ Prenatal Sheet
☐ Most Recent Fetal Assessment Report ☐ Perinatal Triage Assessment Record ☐ Vital Signs Flow Sheet

Follow Up Appointment Dates:

Physician: _____ Fetal Assessment: _____ Other: _____

Completed by:

_____ SIGNATURE

_____ PRINTED NAME AND DESIGNATION

Date: D D M M M Y Y Y Y

Guidelines for Completion of the Antenatal Home Care Program Referral Form

The following key points may assist inpatient sites in making a referral:

1. A call to the Antenatal Home Care Program prior to faxing the referral is necessary to ensure there is room on the program for your patient. Phone 204-792-5463 and if there is no answer leave a name and phone number and a nurse will return your call. The phone and fax numbers for the Antenatal Home Care Program are at the top of the form.
   Antenatal Home Care Program hours: 7 days a week, 08:30 to 16:30. ***If making a referral outside program hours***, please fax the referral to Antenatal Home Care Program and call program @ 204-940-2164 to leave a message advising of referral.

2. The patient referred to the program from hospital normally has the requested information on various forms, within her hospital chart i.e. lab results, vital sign flow sheet. These forms can be faxed as is, rather than having a nurse or unit clerk duplicate information by writing it out again on the referral form.

3. Use ***addressograph*** to avoid writing in key demographic information.

4. ***Referral Source:*** Please indicate if the referral to the Antenatal Home Care Program was discussed with the client (yes or no) and the source of referral, including the date the patient was seen.

5. Hospital ***admission date and discharge date:*** a referral form may be sent on a client prior to discharge home. The Antenatal Home Care Program nurse will refer to the discharge date, and on that date will confirm patient has gone home and whether any changes in condition have occurred.

6. Complete ***address, temporary address*** if applicable, and ***phone numbers (home and cellular)*** as this is vital information to ensure that the client can be contacted and visited promptly after she leaves hospital.

7. ***Gravida/Parity/Gestation and Estimated Date of Confinement***: must be completed.

8. ***Diagnosis:*** please check the box preceding the condition patient requires monitoring of.

9. Assessment/***Condition Summary***: (past 24 hrs): no need to complete if sending by fax the vital signs flow sheet from patient chart. List frequency of warning signs and symptoms related to current condition, presence of any chronic illnesses, previous pregnancy complications. When client has received corticosteroids in hospital, note it here.

10. ***Blood Pressure Cuff Size***: indicate by checking appropriate sized cuff that was ***used on the patient in the hospital***.
    The Antenatal Home Care Program lends each gestational hypertension patient an auto blood pressure cuff - knowing in advance the cuff size ensures the proper cuff is brought to the visit.

11. ***Weight***: most recent weight in kilograms.

12. ***Current Medications***: complete name, dose and schedule for all medications client is to take when at home.

13. ***Accompanying Documentation required***: check off the items being sent with referral form. All items listed are requested by the program.

14. ***Follow up Appointment Dates***: identify dates as booked. If return appointment needs to be arranged by patient or program nurse, write that in.

15. ***Completed by***: (Print)/(Signature) of person completing the form. Used by Antenatal Home Care Program nurses as contact for more information when required.

16. ***Date:*** date the form once completed. This referral form becomes the first portion of the patient's chart and should include the date the information was transferred to the Antenatal Home Care Program.

Created December 2015, MLohre/KDaeninck/CCurtis