



### IN-HOME BLOOD COLLECTION REFERRAL

(Venipuncture only. Collection from lines, catheters, ports, etc. must be referred to Continuing Care.)

Fax to:  Western Zone: 902-527-2994  Eastern Zone: 902-567-3682 (Industrial Cape Breton)
 Northern Zone: 902-752-6184  Central Zone: 902-422-0893

Complete and accurate referral form, and associated laboratory requisition, must be received together. Individual documents will be faxed back to the sender for completion, and may delay service.

CLIENT INFORMATION
Client Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
HCN: \_\_\_\_\_ DOB: (YYYY/MON/DD): \_\_\_\_\_ Client Phone: \_\_\_\_\_
Civic Address: Street/Apt: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_
Service Address
 Same as Civic Street/Apt: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_
 Contact Client directly OR  Contact person listed below
Contact Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_
CRITERIA FOR BLOOD COLLECTION REFERRAL
This referral is for blood collection only where (check all that apply):
 Client is unable to leave their home due to illness  Require isolation due to illness  Mobility challenges or risk of undue hardship
If none apply, please refer patient to http://www.nshealth.ca/blood-collection for regular blood collection service. Online booking is available.
PRE-VISIT RISK IDENTIFICATION / WORKER SAFETY
 Yes  No To your knowledge, is there any reason a home visit to this client may pose a risk to staff?
If Yes, provide details: \_\_\_\_\_
SERVICE REQUIREMENTS - Laboratory Requisition must be submitted with this referral
Is this a request for recurring services?
 Yes  No Frequency:  Weekly  Biweekly  Monthly  Other: \_\_\_\_\_
Duration (max. 12 months): \_\_\_\_\_
Is there a specific collection date / time required? If yes, please specify date / time: \_\_\_\_\_ / \_\_\_\_\_
(YYYY/MON/DD) (Time)
Every attempt will be made to accommodate specific date / time sensitive requests.
CLIENT CONSENT
 Yes  No Client has consented to referral
 Yes  No  N/A Client has an active Substitute Decision Maker (SDM) and the SDM has consented to referral.
(Send completed documents with referral.)
 It has been explained to the client / SDM that if they consent to service, they are also consenting to the sharing of personal health information with other care providers in the circle of care.
REFERRING PHYSICIAN / NP INFORMATION
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
Address: \_\_\_\_\_
Meditech Mnemonic (Northern, Eastern, Western zones): \_\_\_\_\_ License / PMB #: \_\_\_\_\_
FAMILY PHYSICIAN / NP INFORMATION (if not same as REFERRING PHYSICIAN / NP)
Name: \_\_\_\_\_ License / PMB #: \_\_\_\_\_ Mnemonic: \_\_\_\_\_
Address: \_\_\_\_\_
REFERRAL INFORMATION
Person to contact regarding Referral: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
Date of Referral (YYYY/MON/DD): \_\_\_\_\_
Person completing the Referral: \_\_\_\_\_ Phone: \_\_\_\_\_

