McMaster Children's Hospital
HAMILTON HEALTH SCIENCES

PEDIATRIC COMPLEX CARE TEAM REFERRAL

Extension 76340 Fax 905-308-7548

Referral Date: (yyyy/mm/dd) _____

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )	Ext.	
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

REFERRING PROFESSIONAL

Printed Name: _____

Signature and Designation: _____

Phone: _____ Fax: _____

REASON FOR REFERRAL (Please complete all sections)

Objectives for referral to Complex Care: _____

_____

Specific areas that the Complex Care Team can help with: _____

_____

DIAGNOSIS

Primary: _____

Secondary: _____

Under 18 years of age and meets at least one criterion from EACH of the following four conditions:

1. TECHNOLOGY DEPENDENT AND / OR USERS OF HIGH INTENSITY CARE *(please check ALL that apply)*

☐ Child is dependent at least part of each day on mechanical ventilators (invasive, non-invasive) and/or

☐ Child has prolonged (1 month or more) dependence on other devise-based support, including:
Tracheostomy, NPT, Suctioning, home Oxygen support, tube feeding

☐ Child is not technologically dependent but has chronic condition that requires as great a level of care as the above group, such as: Children who require constant medical or nursing supervision or monitoring resulting from the complexity of their condition and/or the complexity of medication/therapy they receive

2. FRAGILITY *(please check ALL that apply)*

☐ The child has severe and/or life-threatening condition, remains at significant risk of unpredictable life-threatening deterioration.

☐ Failure of equipment/technology places child at immediate risk resulting in negative health outcome.

3. CHRONICITY

☐ Child's condition is expected to last 6 months or more

4. COMPLEXITY *(please check ALL that apply)*

☐ Involvement of multiple healthcare practitioners/teams ☐ Need for intensive care coordination

☐ Healthcare services delivered in at least three locations, such as:
Home, School, Hospital, Children's Treatment Centre, Community-based services

SUPPORTING MEDICAL INFORMATION

Does patient currently have a: Family Physician: _____

Pediatrician: _____

Provide any additional relevant information: _____

_____

FOR HHS USE ONLY

Reviewed by: Health Care Professional _____ (Printed Name) _____ (Signature & Designation) _____ (yyyy/mm/dd)

Inpatient Consult Date: (yyyy/mm/dd) _____

Outpatient Appointment booked for - Date: (yyyy/mm/dd) _____ Time: (hh:mm) _____

Referrals *(Sovera document type)*