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

Last Name:________________First: _______________

PHIN:__________________DOB: ________________

COMMUNITY INTRAVENOUS PROGRAM (CIVP)

URGENT HYDRATION REFERRAL FORM

<u>FAX CIVP: (204) 233-0086**</u>**

<u>NRC Contact Number (204) 794-2180</u>

ALL FIELDS MUST B FILLED IN BEFORE FAXING

ADDRESSOGRAPH

Client Information

Name: ___________________________ PHIN: ____________________ Date of Birth: ______________________

Client Room Number / Location:

COVID-19 Status: _________________ ACP Status: _______________ ___________________________________

Weight: (kg) ____________________ Height: (cm) _________________

Allergies / Reactions:

Referring Facility

FACILTY and ROOM NUMBER

Facility Contact Person at Time of Treatment: __________________________

Name and Contact Information for Available Prescriber: _____________________

Diagnosis

Reason for Referral:

Relevant Medical History:

Has Hypodermoclysis been initiated? ☐ Yes ☐ No

Treatment Plan

Resident's age, clinical frailty, cardiac history, medication and medical history and severity of hydration should be considered when deciding on volume and rate of infusion

Options:

☐ 0.9 % NS 250 cc bolus over 60 min, then 125 cc/hr for 2 hrs

OR

☐ 0.9 % NS 150 cc/hr x 4 hrs

<u>If ongoing fluid hydration is required, please re-consult and send referral to CIVP**</u>**

Is wound care required? ☐ Yes ☐ No Has client been assessed by a physician in person? ☐ Yes ☐ No

Date: _________________________ Prescriber Signature: _____________________________

Variables impacting on care requirements

☐ Blindness ☐ Deafness ☐ Quadriplegia/Paraplegia ☐ Cognitive Impairment ☐ Combative

Language spoken:_______________________________ Interpreter required: ☐ Yes ☐ No

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