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

Manitoba Home Nutrition Program
425 Elgin Avenue, Lower Level
Winnipeg, MB
R3A 1P2
Ph: 940-1911

Addressograph

FAX/REFERRAL FORM

To: MHNP	From: _____
Fax: 940-1933	Fax: _____
Ph: 940-1911	Ph:

SECTION A

CLIENT INFORMATION

Nutrition Support Requested: □Tube Feeding □ TPN □ Hydration
Expected Duration of Nutrition Support: _____
Planned Discharge Date:_____
Primary Care Physician: _____
Diagnosis: _____
Relevant Medical & Surgical History:_____
_____
Other Services Consulted: □ Home Care □ Palliative Care □ Long Term Care □ Social Work
MRSA + □ yes □ no VRSE+ □ yes □ no

SECTION B

TYPE OF FEEDING TUBE

□ Tube has been inserted □ Tube to be inserted in the future
□ Balloon GT □ PEG (non-balloon GT) □ Jejunostomy □ N/G □ N/J
Brand Name:_____Size:_____
Insertion Date: Surgeon/Physician:

CURRENT FEED REGIME

□ gravity □ Pump □ Syringe
Formula: _____Amount_____Frequency _____
H2O Flushes:

SECTION C

CENTRAL VENOUS ACCESS DEVICE

□ tunnelled central line □ Port-A-Cath □ PICC Size:_____
□ single lumen □ double lumen □ triple lumen
Insertion Date: Physician/Nurse:

SECTION D

EDUCATION

Who will be taught? □ client □ caregiver □ both □ other_____
Interpreter required? □ yes □ no
Variables affecting learning: □ ambulation □ dexterity □ vision □ hearing □ speech
Contact ph# of learners other than the client:_____

FAX THIS SIDE ONLY Retain original on patient chart.

File Name: Y\ Forms\Fax Referral October 2008

MHNP <u>TUBE FEEDING</u> REFERRAL CHECKLIST:
The following must be completed & sent with the referral:

Task	Date	Initial
Completed sections A, B & D		
Copy of Nutrition Assessment: Acute Care		
Medication list with type, dosage, route & frequency		
Surgeon's report of tube insertion		
Speech Language Pathologist Assessment (if applicable)		

Fax MHNP the following within 48 hours of client discharged:

Task	Date	Initial
Discharge Summary (Pediatrics)		
Pediatric Tube Feeding Discharge Information Sheet (Pediatrics)		

MHNP <u>TPN</u> REFERRAL CHECKLIST:
The following must be completed & sent with the referral:

Task	Date	Initial
Complete Sections A, C & D ----------B (if applicable)		
Copy of Nutrition Assessment: Acute Care		
Medication list with type, dosage, route & frequency		
Present TPN Prescription including rate & hours of infusion		
Resent bloodwork results that include: CBC, INR, PTT, NA, K, Cl, G, U, CR, CA, P, MG, TP, AL, CH, TG, ALK, ALT, AST, TB, DB, iron, ferritin, PALB, vitamin D25, ZN, copper		
Surgeon/Nurses report of central line insertion		
Copy of documentation that supports central venous access device tip location (ex. chest x-ray)		

MHNP <u>HYDRATION</u> REFERRAL CHECKLIST:
The following must be completed & sent with the referral:

Task	Date	Initial
Completed sections A, C & D		
Surgeon/Nurses report of central line insertion		
Copy of documentation that supports central venous access device tip location (ex. chest x-ray)		