Capital Health
Continuing Care

Physician Order Form

FAX TO (902)455-3809 (For all Physician Orders except Home Oxygen and Blood Transfusion)

Client Name _____ _____
Last Name First Name Initals

Health Card # _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/

Referring Physician
Please print _____

Contact Phone: Cell: Fax:

Community/Family Physician (MD, NP) _____

Please print

Contact Phone: Cell: Fax:

_____

Diagnosis _____

Allergies _____

Treatment Orders:

Start date: _____ **Duration (if applicable):** _____

If requesting wound care, please check the box below
☐ Follow NS Wound Protocol

When the Community/Family Physician and Referring Physicians are NOT one and the same:

☐ The Community/Family Physician has been contacted and has agreed to provide direction to community nurses to follow the client in the community.

Referring Physician's Signature _____ Date_____