# 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: 902−567−7947**
❑ **Northern Zone: 902−752−1931** ❑ **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)

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 Referrral: _____ Phone: _____ Fax: _____

Date of Referral (YYYY/MON/DD): _____

Person completing the Referral: _____ Phone: _____