

NORMAN RECOLLET HEALTH CENTRE
Policies and Procedures Manual

REFERRAL TO OTHER SERVICES POLICY

Category: Client Care	Subject: Referral to Other Services	Policy Number: C.2
Approved by: Chief and Council	Subject Sub-title:	
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Policy Statement:

One important role of the Home Care Nurse is to ensure implementation of the clinical treatment plan and care plans by facilitating referrals to services not provided on site.

Referrals should meet the client needs identified and prioritized by the physician, the Home Care Nurse and the Nurse Practitioner during the intake and needs assessment process and integrated into the care plan.

Services to which clients are referred must be appropriate to the needs of the client, be accessible to the client in terms of culture, physical location, and cost. Following the referral of a client, the Home Care Nurse must follow up with the client and the service provider to whom the client was referred, to ensure that services were accessed.

It is the Home Care Nurse's role to assist the client with mediating any barriers to accessing services (e.g. travel, scheduling, etc.) as well as any perceived stigma in seeking assistance from core service providers e.g. mental health and substance abuse.

All referrals are to be reported and tracked in the Norman Recollet Health Centre EMR system.

Minimum Requirements

- Referrals must be appropriate to the client's identified and prioritized needs.
- Referred services must be accessible to client.
- Referrals must be documented in EMR system.
- The referral should be discussed with the client.



- The Home Care Nurse must follow up on urgent referrals with the receiving agency/provider and the client immediately. For all other referrals, follow up with client as part of your monthly client contact and review of their care plan.
- Referral follow-up must be documented in the PS Suite Case Notes, including any barriers to accessing services and steps to overcome those barriers.
- Referral discussions must be included in case conferences at least twice during the program year once the program is developed.

Procedure

Services the client is referred to must be:

- Accessible in terms of physical location, transportation, culture/language, and cost.
- Appropriate to the client's needs.
- Presented to the client in a manner that lends itself to completion.

For each referral:

Provide the client with a description of the service you are referring them to and the reason for the referral, e.g. 'Your doctor has asked...'

The description should include:

- Any eligibility criteria
- any time-sensitive aspects to the service (i.e. application deadlines, appointment schedules, etc.).
- phone number and contact person. (The Home Care Nurse and client may call during the session to arrange the appointment).

Make an initial call on behalf of the client to the agency/provider you are referring the client:

This is to ensure that:

- the service is still available
- that the receiving provider has the current capacity to serve the client.

The Home Care Nurse completes the Referral Form to Another Organization to link clients with other services.

The referral is documented in the client's file and the EMR.

Provide the client with the necessary contact information to follow up on the appointment.

This should include, at a minimum:

- The appointment date and time
- The location of the agency where the appointment is to be held and any information needed on how to get there (i.e. directions, public transportation information, voucher, etc.)
- The receiving provider's name and telephone number

Record all of the referrals you make for the client in the client's EMR care plan.



Appendix A: NRHC Referral Form

Norman Recollet Health Center Referral Form

Wahnapiitae First Nation

259 Taighwenini Trail Rd.
Capreol Ontario P0M 1H0
Tel: 705-858-7700
Fax: 705-858-6770

Client Information

Name:	Date of Birth:
Parent or Guardian (if under 18):	Family Doctor:
Band Number:	Health Card Number:
Mailing Address:	City:
Postal Code:	Phone Number:
Emergency Contact: <i>Relation:</i> <i>Phone Number:</i>	

Requesting Referral

- Nurse Practitioner
- Mental Health Worker
- Community Health Nurse
- Medical Administrator
- Foot Care Nurse
- Healthy Babies Healthy Children
- Jordans Principal Navigator
- Dental Hygienist
- Family Well Being



Referral Source Information

Name of Person Completing this Form:	Telephone: Fax:
E-mail:	Name of Organization:
Program:	Additional Comments:
Parent or Guardian aware of referral: <input type="radio"/> Yes <input type="radio"/> No	
Signature:	Date:

Approved by: _____ Date: _____
Health Director

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

