

Outpatient Complex Care Program Referral - Pediatrics

Criteria for Referral: (all criteria must be met)					
	☐ Must be less than 16 years of age.				
	Must be followed by at least five PHYSICIAN sub-specialists.				
<u> </u>	(as c	t check one or more box in EACH of the four sections below to meet Medical Complexity defined by Provincial Council for Maternal and Child Health & Complex Care Kids Ontario, 2015) or the tional considerations proviso.			
1.]	1. Technology Dependent and/or users of high intensity care:				
		Child is dependent at least part of each day on mechanical ventilators, and/or child requires prolonged intravenous administration of nutritional substances or drugs and/or child is expected to have prolonged dependence on other device-based support (for example: tracheostomy tube care/artificial airway, suctioning, oxygen support, or tube feeding), and/or			
		Child has prolonged dependence on any other medical devices to compensate for vital bodily functions, and requires daily or near daily nursing care (for example: cardiorespiratory monitors, renal dialysis due to kidney failure, urinary catheters or colostomy bags plus substantial nursing care), and/or			
		Child is not technologically dependent but has any chronic condition that requires as great a level of care as the above group, such as:			
		 Children who, as a consequence of their illness, are completely physically dependent on others for activities of daily living at an age when they would not otherwise be so dependent, 			
		 Children who require constant medical or nursing (or delegate with competency) supervision or monitoring resulting from the complexity of their condition and/or the complexity of medication administration and/or the quantity of medication and therapy they receive. 			
2.	2. Fragility:				
		The child has severe and/or life-threatening condition, lack of availability and/or failure of equipment/technology or treatment places the child at immediate risk resulting in a negative health outcome, and/or			
		Short-term changes in the child's health status (illness) put them at immediate serious health risk, and/or			
		As a consequence of the child's illness, the child remains at significant risk of unpredictable life-threatening deterioration, necessitating round-the-clock monitoring by a knowledgeable caregiver, and/or			
		Likely to experience exacerbation of chronic condition necessitating assessment by a healthcare provider in a timely manner.			
3. Chronicity:					
		The child's condition is expected to last at least six more months, or			
		The child's life expectancy is less than six months.			



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4. Complexity:

- ☐ Involvement of at least five healthcare practitioners/teams and healthcare services are delivered in at least three of the following locations:
 - Home
 - School / Nursing school
 - Hospital
 - Community-based clinic (e.g. doctor's office)
 - Other (at clinician's discretion)
- ☐ The family circumstances impede their ability to provide day-to-day care or decision making for a child with medical complexity (for example, the primary caregiver and/or the primary income source are at risk of not being able to complete their day-to-day responsibilities).

Additional Considerations:

Patient is a newborn or has received a new diagnosis; while they currently do not meet criteria, consistent with their diagnosis/condition, it is strongly predicted that they will meet full Complex Care criteria within the next calendar vear.

If this patient meets criteria for Complex Care, they, by definition, have a life limiting condition and will simultaneously be referred to the Pediatric Care Team (PACT).

Please be advised that if your referral does not meet criteria, it will be forwarded to IWK General Pediatrics to be triaged for the General Pediatric Clinic. Additionally, if patients have a less complex outcome than expected, they will be transitioned to General Pediatrics.

Referrals will not be accepted for the purpose of care coordination. Patient Name:

Date of Birth:

Provincial Health Card Number: Parent(s)/Caregiver:

Address: Telephone (1): Telephone (2):

Primary Language: _____ Diagnosis & Reason for Referral:





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Specific Concerns:				
Other Relevant Information:				
-				
Complex Care Plan Included?				
Patient Summary Included?				
'				
If so, which hospital?				
Estimated date of discharge				
Organization / Health Centre:				
Contact: Telephone (1): Telephone (2):				
Name of community primary care provider:				
Does patient have a pediatrician?	:			
		Date of Referral		
Referring Physician (Print Name)	Referring Physician (Signature)	(yyyy/mon/dd)		

Please fax completed referral form to 902-470-7928



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