THE NOVA SCOTIA HEALTH HOME TOTAL PARENTERAL NUTRITION (TPN) PROGRAM REFERRAL

Referral Form

- Please fax this referral form and relevant documents to 902-473-3966.

Urgent Referral: ❑ Yes ❑ No
(ex: patient is currently admitted and needs home PN coordination ASAP)

Criteria for Program Eligibility: (Patient must meet *all* the below criteria)

1. Have a non-functioning gastrointestinal tract, as determined by a gastroenterologist.
2. Have demonstrated intolerance or contraindications to enteral nutrition via nasogastric/gastrostomy, nasojejunal, or jejunostomy tubes for a minimum trial of two to four weeks.
3. Be hospital dependent on parenteral nutrition (PN) with demonstrated therapeutic benefits while receiving PN.
   - They must be metabolically stable for a period of weeks, without frequent alterations to PN solution, and cyclic PN must have been initiated (example: 16, 12, 10 hours overnight).
4. Require home PN for longer than six months.
5. Be ambulatory and able to care for all personal needs, unassisted.
6. Have a care partner able to learn the procedures for support, as needed.
7. Have a back-up plan for emergencies (example: power outage).
8. Be a resident of Nova Scotia.
9. Have a single-lumen central tunneled catheter (Hickman ®) in situ.
   - **Note:** This is **not** a Port-a-Cath or peripherally inserted central catheter (PICC).
10. Able to participate in inpatient discharge teaching at the Victoria General (VG) or Halifax Infirmary (HI) site.

Referring Provider Responsibilities:

- ❑ Arranging with the closest Interventional Radiology (IR) site (or the VG/HI/ IR service) to have a Hickman® line inserted, if not currently in situ.
- ❑ Collaborate with a VG/HI health care provider for the patient's transfer (under the accepting health care provider's care for teaching purposes).
- ❑ Ensure this form is complete and faxed, with relevant documentation attached.

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Patient Information
Name: _____ (last) _____ (first) Date of Birth: _____ (YYYY/MON/DD)
Allergies: _____
_____
_____
Address (street, apartment): _____ City: _____
Province: _____ Country: _____ Postal Code: _____
Phone Number: _____
Alternate Contact Person: _____ Relationship: _____
Phone Number: _____

Brief Summary of Indication for Home Parenteral Nutrition
_____
_____
_____

Please Attach Copies of the Following	
❑ Medical History	❑ Operative Reports (i.e., bowel resections, etc.)
❑ Central Venous Catheter (CVC) Access Device Insertion Record	❑ Diagnostic Tests (i.e., endoscopy, imaging, etc.)
❑ Lab Work	❑ Medication List

Name of Referring Provider:
Clinical Site:
Date (YYYY/MON/DD)**:**
Phone Number:
Email:

Please contact the home TPN office at 902-473-2873 for questions and concerns.