

Advanced Collaborative Care Plan (ACCP)

Request Form

Fax: 604-875-2742

| Referral For | Referral Timelines | | | | | | | | |
|--|---|--------------|--|---|---|-----------------|-----------------------|--|---|
| <p style="text-align: center; color: #ccc;">PATIENT NAME OR LABEL</p> <p>PHN: _____</p> <p>Phone: _____</p> <p><input type="checkbox"/> Patient aware of ACCP request</p> | <p><input type="checkbox"/> ≥ 8 weeks prior to anticipated delivery</p> <p><input type="checkbox"/> 3-8 weeks prior to anticipated delivery</p> <p style="margin-left: 20px;"><input type="checkbox"/> Change in Health Status</p> <p style="margin-left: 20px;"><input type="checkbox"/> New Concern Identified</p> <p><input type="checkbox"/> <3 weeks prior to anticipated delivery may not be accommodated and will be evaluated on a case by case basis</p> | | | | | | | | |
| <p>G ___ T ___ P ___ A ___ L ___</p> <p>EDD: _____ <input type="checkbox"/> 1st trimester U/S</p> | <p>ACCP Request MUST come from Maternal MRP</p> <p>MRP: _____</p> <p>Office Phone: _____</p> <p>Fax: _____</p> <p>If a consultant determines an ACCP is appropriate, they MUST initiate the process through the MRP.</p> | | | | | | | | |
| Intended Mode of Delivery | | | | | | | | | |
| <p><input type="checkbox"/> Vaginal Birth</p> <p><input type="checkbox"/> Induction Date/GA: _____</p> <p><input type="checkbox"/> Caesarean Birth Date/GA: _____</p> | <p style="text-align: center;">Indication(s) for Referral</p> | | | | | | | | |
| Consults Initiated | | | | | | | | | |
| <table border="0" style="width: 100%;"> <tr> <th style="width: 50%; text-align: left;"><u>Maternal</u></th> <th style="width: 50%; text-align: left;"><u>Fetal</u></th> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Maternal Fetal Medicine <input type="checkbox"/> Obstetrician <input type="checkbox"/> Anesthesia <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Hematology <input type="checkbox"/> Perinatal Addictions <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> NICU <input type="checkbox"/> Cardiology <input type="checkbox"/> PICU <input type="checkbox"/> Pediatric Subspecialty: _____ <input type="checkbox"/> Canuck Place </td> </tr> </table> | <u>Maternal</u> | <u>Fetal</u> | <input type="checkbox"/> Maternal Fetal Medicine <input type="checkbox"/> Obstetrician <input type="checkbox"/> Anesthesia <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Hematology <input type="checkbox"/> Perinatal Addictions <input type="checkbox"/> Other: _____ | <input type="checkbox"/> NICU <input type="checkbox"/> Cardiology <input type="checkbox"/> PICU <input type="checkbox"/> Pediatric Subspecialty: _____ <input type="checkbox"/> Canuck Place | <table border="0" style="width: 100%;"> <tr> <th style="width: 50%; text-align: left;"><u>Maternal</u></th> <th style="width: 50%; text-align: left;"><u>Fetal/Neonatal</u></th> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Significant Disease(s) <input type="checkbox"/> High Acuity Level of Care <input type="checkbox"/> Complex Surgical Care <input type="checkbox"/> Mobility Limitations <input type="checkbox"/> Mental Health <input type="checkbox"/> Complex Social Concerns <input type="checkbox"/> Request for Care Variances <input type="checkbox"/> Inter-Hospital Coordination <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Significant Risk to Newborn Transition <input type="checkbox"/> Congenital Heart <input type="checkbox"/> Airway Management <input type="checkbox"/> Other: _____ <input type="checkbox"/> Significant Congenital Abnormality <input type="checkbox"/> Higher Order Multiples (Triplets or greater) <input type="checkbox"/> Palliative Care <input type="checkbox"/> Multiple Service Coordination <input type="checkbox"/> Inter-Hospital Coordination </td> </tr> </table> | <u>Maternal</u> | <u>Fetal/Neonatal</u> | <input type="checkbox"/> Significant Disease(s) <input type="checkbox"/> High Acuity Level of Care <input type="checkbox"/> Complex Surgical Care <input type="checkbox"/> Mobility Limitations <input type="checkbox"/> Mental Health <input type="checkbox"/> Complex Social Concerns <input type="checkbox"/> Request for Care Variances <input type="checkbox"/> Inter-Hospital Coordination <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Significant Risk to Newborn Transition <input type="checkbox"/> Congenital Heart <input type="checkbox"/> Airway Management <input type="checkbox"/> Other: _____ <input type="checkbox"/> Significant Congenital Abnormality <input type="checkbox"/> Higher Order Multiples (Triplets or greater) <input type="checkbox"/> Palliative Care <input type="checkbox"/> Multiple Service Coordination <input type="checkbox"/> Inter-Hospital Coordination |
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| Requests Will Not Be Processed Without: | | | | | | | | | |
| <p><input type="checkbox"/> Antenatal Records 1 and 2</p> <p><input type="checkbox"/> Consultation Reports (Maternal)</p> <p><input type="checkbox"/> Consultation Reports (Fetal)</p> <p><input type="checkbox"/> Labs</p> <p><input type="checkbox"/> Diagnostic Imaging:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Obstetrical Ultrasound</p> <p style="margin-left: 20px;"><input type="checkbox"/> Fetal Echo</p> <p style="margin-left: 20px;"><input type="checkbox"/> Maternal Echo</p> <p>Other: _____</p> | <p style="text-align: center;">Referral Details:</p> | | | | | | | | |

Date: _____ Signature: _____

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Developed By

Fetal Maternal Newborn Program – Senior Practice Leader

Version History

| DATE | DOCUMENT NUMBER and TITLE | ACTION TAKEN |
|-------------|--|--|
| 23-Apr-2019 | C-06-06-60193 Advanced Collaborative Care Plan (ACCP) Request Form | Approved at: Perinatal Best Practice and Neonatal Leadership Committee |

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