Ontario Health atHome

PRINT FORM

COPD & Heart Failure Telehomecare Referral Form

Please fax referral forms(s) to: 905-444-2555
or 1-855-352-2555

PATIENT INFORMATION

Referral Date (DD MM YYYY): ____ / ____ / ____

LAST NAME	FIRST NAME	DATE OF BIRTH (DD MM YYYY)	
MRN	HEALTH CARD NUMBER (OHIP)	VC	GENDER ○ MALE ○ FEMALE
ADDRESS	CITY		
POSTAL CODE	PRIMARY PHONE NUMBER		
FIRST LANGUAGE	SECONDARY CONTACT & PHONE NUMBER		

ELIGIBILITY FOR TELEHOMECARE SERVICES

- ☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).
- ☐ Patient has a fixed address and a phone.
- ☐ The patient is capable of managing monitoring equipment (BP and O2 monitors, scale). The patient is able to read and answer questions (yes/no multiple choice) using a computer tablet.
- ☐ Patient meets criteria for Virtual COPD clinic (CONFIRMED diagnosis of COPD with exacerbations leading to ED visit or hospitalization)

- ☐ **Patient consents to participate in Telehomecare***
- ☐ **Patient consents to participate in Patient Experience Survey**
- ☐ **Opt out of Survey**

Patient Signature: _____

(*Monitoring equipment will NOT be delivered unless patient has provided written consent)

- ☐ **Verbal consent obtained**

MAIN DIAGNOSIS FOR MONITORING

☐ COPD ☐ Heart Failure BP Cuff Size Required: ☐S ☐M ☐L

CO-MORBIDITIES

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension ☐ CKD
☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other _____

REFERRER'S INFORMATION

☐ I would like to receive patient reports _____ SIGNATURE

NAME	ORGANIZATION	CPSO/CNO NUMBER
POSITION	OTHER DESCRIPTION	NAME/ADDRESS STAMP
ADDRESS		
PHONE NUMBER	FAX PHONE NUMBER	

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately.

PRIMARY CARE PROVIDER'S INFORMATION

☐ Same as previous page

NAME	CPSO/CNO NUMBER
ADDRESS	

A complete and current medication list would be helpful.

Please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges) if available.

PHYSIOLOGIC PARAMETERS

The following patient vitals will be monitored:

CHF DEFAULT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE	WEIGHT (LBS.)
High	150	100	100	100	+2 lbs/ DAY
Low	90	60	92	50	-5 lbs/ DAY

COPD DEFAULT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE	WEIGHT (LBS.)
High	150	100	100	100	+5 lbs/ WEEK
Low	90	60	88	50	-5 lbs/ WEEK

The default parameters **ABOVE** will be used unless specific patient parameters are provided **BELOW**:

PATIENT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE

MEDICATIONS

☐ Current medication list attached (or can be recorded below).

☐ Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES