Ontario Health atHome

TELEHOMECARE REFERRAL FORM

Please fax referral forms to: 705-670-3805

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or provide any relevant information.

PATIENT INFORMATION **Referral Date** (DD MM YYYY): _____

Last Name:	First Name:	Date of Birth (DD/MM/YYYY):
Health Card Number (OHIP)	VC	Gender ☐ Male ☐ Female
Address:	City	
Postal Code:	Primary Phone Number:	
First Language:	Second Language:	

Eligibility for Telehomecare Services

- ☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).
- ☐ Patient lives in a residential setting with internet connection or availability of cellular connectivity.
- ☐ Health care provider feels the patient will benefit from Telehomecare. (This would require the patient or caregiver being able to operate simple equipment.)
- ☐ Patient or family caregiver is able to provide informed consent to participate.

Main Diagnosis for Monitoring:

☐ COPD or ☐ Heart Failure

Co-Morbidities:

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Cancer ☐ Osteoporosis ☐ Other:

REFERRER'S INFORMATION

Name:	Organization:	CPSO/CNO Number:
Position:	Other Description:	Name/Address Stamp
Address		
Phone Number:	Fax Phone Number:	

PRIMARY CARE PROVIDER'S INFORMATION ☐ Same as above

Name:	CPSO/CNO Number:
Signature:	

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	50	90	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/ Day

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

Patient	Systolic BP	Diastolic BP	Oxygen Sat.	Pulse
High				
Low				

I would like to receive reports :

- ☐ Once per month and on significant change
- ☐ Once per 2 months and on significant change
- ☐ Once per 3 months and on significant change
- ☐ No monthly reports, Report significant changes only

Please note that unless otherwise indicated reports will be sent at all significant change, on enrollment and upon discharge.
Also please indicate if you would like data trends included with these reports: YES ☐ NO ☐

☐ Current medication list attached

☐ Contact pharmacy for medication list

Additional Information or Notes:

Printed Name – Referrer | Signature/Designation | Date (DD/MM/YYYY)

Printed Name – Primary Care Provider | Signature/Designation | Date (DD/MM/YYYY)

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.