Ontario Health atHome

# Telehomecare – Remote Monitoring Program
# Referral Form

**Please fax to:**
**613.745.8243 or**
**1.855.450.8569**

**1) Are you referring for nursing, PSS, OT, PT, dietician, SW or SLP services?** If so, *do not use this form* and instead use our Medical Referral or Infusion Therapy / Venous Access Referral form.

**2) Which program are you referring to?**

**a) Remote Monitoring for** ☐ COPD ☐ Heart failure ☐ COVID-19 ☐ Diabetes

**b) Enhanced In-Home Remote Monitoring Pilots**, which include RRN visits, remote monitoring, community paramedics, hospital partnership. *** Hospital is responsible for faxing referral to Ottawa Community Paramedics or Prescott Russell Community Paramedics. ***

**Which site?** ☐ Hôpital Montfort ☐ Queensway Carleton Hospital

**Which pilot?** ☐ COPD ☐ Heart failure ☐ ALC ☐ Diabetes ☐ Cellulitis or osteomyelitis

**3) Patient Information**

| | | | |
|---|---|---|---|
| Referral Date | | Planned Discharge Date | |
| Last Name | First Name | | DOB _____ (DD MM YYYY) |
| HCN (OHIP) | | VC | Gender |
| Address | | City | |
| Postal Code | Primary Phone | Mobile | |
| 1st Language | | 2nd Language | |

**4) Eligibility** (check all that apply)

☐ Patient has an established diagnosis (probable cases of COVID-19 are accepted)

☐ Frequent hospital admissions, visits to ED, primary care provider (PCP) and/or difficulty managing symptoms (i.e., anxiety, shortness of breath, edema).

☐ Health care provider feels patient will benefit from Telehomecare.

☐ Patient or caregiver is able to provide informed consent to participate

**5) Main Diagnosis for Monitoring** ☐ COPD ☐ Heart failure ☐ COVID-19 ☐ Diabetes

**Co-morbidities:**

☐ Diabetes ☐ COPD ☐ Heart failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other

**6) Physiologic Parameters** - the following vitals will be monitored

| **Heart Failure 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 you provide specific patient parameters BELOW:

| **Patient** | Systolic BP | Diastolic BP | Oxygen Sat | Pulse | Weight (lbs.) |
|---|---|---|---|---|---|
| High | | | | | |
| Low | | | | | |

**7) Referrer Information**

I would like to receive patient reports ☐ Yes ☐ No

| Name | Position | CPSO/CNO Number |
|---|---|---|
| Organization | | Name / Address Stamp |
| Address | | |
| Phone | Fax | |

**8) PCP Information** ☐ Same as above

Does PCP want to receive patient reports? ☐ Yes ☐ No ☐ N/A

| Name | Position | CPSO/CNO Number |
|---|---|---|
| Organization | | Name / Address Stamp |
| Address | | |
| Phone | Fax | |

**9) Additional Information**

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

**10) Medications** ☐ Current medication list attached (or recorded below) ☐ Contact pharmacy for medication list