Ontario Health atHome

COVID-19 Remote Self-Monitoring Program Referral Form

Please fax referral form(s) to: 905-707-2409

PATIENT INFORMATION

_____
(Last Name, First Name)

Home Address: _____

City: _____ **Postal Code:** _____ **Date of Birth:** _____ *(dd/mmm/yyyy)*

Primary Phone: _____ **Cell Phone:** _____ **Email Address:** _____

First Language: _____ **Translator Needed:** ☐ Yes ☐ No

Potential Discharge Date: _____ *(dd/mmm/yyyy)* **Date of Symptom Onset:** _____ *(dd/mmm/yyyy)*

Background for Referral (Check all that apply)

- ☐ Person Under Investigation for COVID-19
- ☐ COVID-19 Positive
- ☐ Patient to self-isolate at home
- ☐ Patient to self-isolate via cohorting space
- ☐ Patient has access to smartphone or other device that can run apps

How would the patient like to receive notification to participate in the program? (Choose one) ☐ By Email ☐ By Secure Text

- ☐ Patient does not own a smart device

Risk Factors

- ☐ Diabetes with complications
- ☐ Congestive heart failure
- ☐ Chronic lung disease (i.e. COPD, emphysema), or moderate to severe asthma
- ☐ Weakened immune system
- ☐ Dialysis
- ☐ Cirrhosis of the liver
- ☐ Neurological conditions that weakened ability to cough
- ☐ Pregnancy
- ☐ Extreme obesity
- ☐ 65 years old or older
- ☐ Lives in long term care facility

Referrer Information

Name: _____

Position: _____

Phone Number: _____

Email Address: _____

Community Pharmacy

Name: _____

Phone Number: _____

Fax Number: _____

Primary Care Provider's Information

Name: _____

Position: _____

Other description: _____

Organization: _____

Address: _____

Phone Number: _____

Fax Number: _____

☐ Same as above

Name / Address Stamp

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provincial 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 information in error, please contact the owner or sender immediately.

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(Patient Last Name, First Name) **Date of Birth:** *(dd/mmm/yyyy)*

Emergency Contacts

Name:	Name:
Relationship *(Indicate if primary contact for patient):*	Relationship *(Indicate if primary contact for patient):*
Phone Number:	Phone Number:

Other Relevant History (please include baseline Oxygen Saturation Levels)

Medications (list of medications and/or additional instructions or notes)

☐ Current medications list attached (or can be recorded below) ☐ Contact pharmacy for medication list

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