Ontario Health atHome

Referral and Treatment Plan

ESHC - Inpatient

☐ Chatham Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

☐ Sarnia Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

☐ Windsor Site
Ph: 1-888-447-4468
Fax:1-844-858-3546

Community: _____

Hospital: _____ Unit: _____

Alternative Contact for Patient: _____

Relationship: _____ Phone: _____

Estimated Date of Discharge (dd/mm/yy) : _____

Patient Demographics

Patient Name: _____

☐M ☐F DOB: _____ (dd/mm/yy)

HCN: _____ VC: _____

Address/911: _____

City: _____ PC: _____

Phone: _____

☐ Patient Agrees to Referral

Service Needed: (Assessment by Ontario Health atHome to determine services in clinic or home)

☐ Nursing ☐Palliative Care ☐PSW ☐Telehomecare ☐Long Term Care ☐Dietician ☐Social Work ☐ PT ☐OT ☐SLP

☐ Behavioural Support Ontario (BSO)

Reason for Referral: _____

Diagnosis: _____

☐ NKA ☐Allergies/Sensitivities: _____

Medical Orders

Best practice/evidenced based practice will be initiated unless otherwise written. Wound care outside of evidenced based practice may not be eligible for Ontario Health atHome services. Treatment will be taught and service reduced when appropriate.

Specify Wound: ☐Surgical ☐Malignant ☐Pilonidal ☐Traumatic ☐Venous Leg Ulcer ☐Arterial Leg Ulcer

☐ Diabetic Foot Ulcer ☐Maintenance ☐Non-Healing ☐Other: _____ Pressure injury:Stage: ☐1 ☐2 ☐3 ☐4

IV Therapy: ☐Peripheral ☐PICC ☐Midline – Catheter Length: Internal: _____ cm External: _____ cm

☐ Subcutaneous ☐Central Number of Lumens: ☐1 ☐2 ☐3

Drug: _____

Dose: _____ Frequency: ☐ q24h ☐ q12h ☐ q8h ☐ q6h ☐ q4h Other: _____

Duration of remaining community treatment: _____ Days (number of) or _____ Doses (number of)

Last Dose in Hospital: Date: (dd/mm/yy) _____ Time: _____ ☐ am ☐ pm ☐ N/A

Community Therapy to Start: Date: (dd/mm/yy) _____ Time: _____ ☐am ☐ pm

☐ ***Has received same medication and route within past 12 months***

☐ ***Has NOT received medication within past 12 months - First Dose Parenteral Screener Completed***

☐ ***REMDESIVIR: Patient qualifies for treatment per Ontario Health and MOH guidelines***

Start time may be delayed up to 8 hours if the next dose due is between midnight to 0800h.

Additional Referral Information/ Specific Health Care Orders: (Infusion orders require frequency, dosage and duration)

Signature	**Print Name/Designation/Title**	**OHIP Billing Code 1**
CPSO/CNO Reg. Number	Phone Number	Date (dd/mm/yy)

[1]Physician use only. Applicable billing as outlined in the Schedule of Benefits for Physician Services under the Health Insurance Act.