Ontario Health atHome

Please fax to:
613.745.8243 or
1.855.450.8569

Telehomecare – Remote Monitoring Program

Referral Form

1) **Non-Enhanced Program:** ☐ COPD ☐ COVID-19 ☐ Diabetes ☐ Heart failure ☐ Frail Elderly ☐ Geriatric rehab

2) **Enhanced In-Home Program** * only for participating hospital sites. ☐ Cellulitis ☐ COPD ☐ Diabetes ☐ Frail Elderly ☐ Geriatric rehab ☐ Heart failure ☐ Osteomyelitis. * **Hospital employees** are responsible for faxing referral to Community Paramedics.

3) **Patient Information**

Designated alternate level of care /ALC?		☐ Yes	☐ No
Referral Date		Planned Discharge Date	
Last Name	First Name	DOB (DD MM YYYY)	
HCN (OHIP)		VC	Gender
Address		City	
Postal Code	Primary phone		Other phone
Language(s) 1st		2nd	

4) **Alternate Contact** ☐ Instead of the patient, contact the alternate for assessment due to: ☐ Hearing ☐ Cognition ☐Preference ☐ Language ☐ Other (specify) _____

Alt Name	Phone
Relationship to patient	

5) **Patient Health Information**

Height	Weight
Primary Diagnosis	

6) **Other Services**

Are you referring for **nursing, PSS, OT, PT, dietician, SW or SLP** services **in addition to the Remote Monitoring Program?**

If yes, please **also** complete and submit the Medical Referral or Infusion Therapy / Venous Access Referral, as appropriate.

7) Default Parameters - the following will be monitored, unless you provide other specifics, below.

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

Patient-Specific Parameters (if not using parameters above)

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

8) Referrer Information I would like to receive patient reports ☐ Yes ☐ No

Name	Position	CPSO/CNO Number
Org		Name / Address Stamp
Address		
Phone	Fax	

9) PCP Information ☐ Same as above**.** Does PCP, specialist or outpatient clinic want to receive patient reports? ☐ Yes ☐ No ☐ N/A

Name	Position	CPSO/CNO Number
Org		Name / Address Stamp
Address		
Phone	Fax	

10) Additional Information

a) What information have you shared with the patient about symptom management, titrating their medications, and / or taking PRN medications?

b) If available, **please also attach** other information (consultant notes, lab or imaging reports, patient-specific health care challenges).

11) **Medications** please list them here, or attach (mandatory)