Ontario Health atHome

Hospital to Home (H2H) Active Patient ODB Request Form

**Requests are only for H2H patients already being supported by H2H program within the community*
***Hospital based patients are to be initiated as per hospital Ontario Health atHome processes*

Patient Name _____

Health Card Number _____ **Version Code** _____ **Date of Birth** _____

Address _____

City _____ **Postal Code** _____ **Contact Phone** _____

Patient Gender ☐ Male ☐ Female ☐ Undifferentiated **Preferred Official Language** ☐ English ☐ French

Request Type

ODB Authorization for Drug Coverage (*please select one of the following):*

☐ Initiation ☐ Extension ☐ End

H2H ODB Program Extension Until (dd/mm/yyyy) _____

H2H ODB Program Discharge Date (dd/mm/yyyy) _____

Pharmacy Information (complete only if initiating ODB from community)

Pharmacy Name _____

Pharmacy Address _____

City _____ **Postal Code** _____

Pharmacy Phone Number _____ **Pharmacy Fax Number** _____

Estimated Length of Stay on H2H Program _____

Estimated H2H ODB Program Discharge Date (dd/mm/yyyy) _____

H2H Program Information

Lead Organization _____ **Contact Name** _____

Contact Phone Number _____

Please fax completed form to Ontario Health atHome H2H ODB team at 1-877-546-4311