

**COPD & Heart Failure Telehomecare Referral Form** Please fax referral forms(s) to:

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or add any relevant information.

**PATIENT INFORMATION**

Referral Date (DD MM YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST NAME	FIRST NAME	DATE OF BIRTH (DD MM YYYY) 
HEALTH CARD NUMBER (OHIP)	VC	GENDER MALE                  FEMALE
ADDRESS		CITY
POSTAL CODE	PRIMARY PHONE NUMBER	
FIRST LANGUAGE	SECOND LANGUAGE	

**ELIGIBILITY FOR TELEHOMECARE SERVICES**

- |  |   |
|--|---|
| <input type="checkbox"/> Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions). | <input type="checkbox"/> Health care provider feels the patient will benefit from Telehomecare. (This would require the patient or caregiver being able to operate simple equipment.) |
| <input type="checkbox"/> Patient lives in a residential setting with an active land line (internet or analog phone line).      | <input type="checkbox"/> Patient or family caregiver is able to provide informed consent to participate.  |

**MAIN DIAGNOSIS FOR MONITORING**
 COPD                   Heart Failure

**CO-MORBIDITIES**

- |                                   |                                    |  |                                     |                                       |
|-----------------------------------|------------------------------------|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD      | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Other _____  |

**REFERRER'S INFORMATION**
 I would like to receive patient reports

NAME	ORGANIZATION	CPSO/CNO NUMBER
POSITION	OTHER DESCRIPTION	NAME/ADDRESS STAMP
ADDRESS		
PHONE NUMBER	FAX PHONE NUMBER	

**PRIMARY CARE PROVIDER'S INFORMATION**
 Same as above

NAME	CPSO/CNO NUMBER
ADDRESS	

A complete and current medication list would be helpful.

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

**PHYSIOLOGIC PARAMETERS**

The following patient vitals will be monitored:

CHF 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 specific patient parameters are provided **BELOW**:

PATIENT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE
High				
Low				

**MEDICATIONS**

- Current medication list attached (or can be recorded below).
- Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES