



Hospital 2 Home 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

Please select one of the following:

ODB drug card initiation ODB drug card extension ODB drug card discharge

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

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

Hospital to Home Program Information

Lead Organization _____ Contact Name _____

Contact Phone Number _____