Ontario
Health atHome

Patient Transition to Ontario Health atHome Referral Form

Service Provider Organizations are required to complete the following referral when referring a patient to Ontario Health atHome. **With this referral, please include assessment information (most recent interRAI HC/CA), updated medical orders, PSW/nursing/therapy assessments and substitute decision maker (SDM) documentation.**

A. Demographic Information

Client Name:	DOB:
Client Phone Number:	HCN and VC:

Address:

Start date of services through the referring home care program:

SDM Name/Contact number:

Primary Care Physician:

Name of the service provider agency providing care:

Primary reason for referral:

Services requested through Ontario Health atHome (include frequency):

Start date with Ontario Health atHome:

ODB required (Y/N):

Supplies and equipment requested from Ontario Health atHome:

B. Patient's Current Functional and Cognitive Status

Relevant health history and diagnosis. include memory status (alert, confused) fall history, hospital/ED admission, and attach recent assessments, hospital discharge summary history and physical and best possible medication history:

I = Independent, **C** = Cueing, **S** = Supervision, **Ax1** = 1 Person Assist, **Ax2** = 2 Person Assist,
Mech = Mechanical Assist, **NA** = Not Applicable

Activities of Daily Living	Current Status	Activities of Daily Living	Current Status
Toileting/Continence		Feeding	
Bathing/Showering		Dressing	
Assistive Device(s) Used		Transfers/Mobility	

Training or supports required (Describe details below):

Social/Environmental Risks: (i.e. smoking, pets, firearms, infestation, hoarding)

C. Current Service and Care Plan Summary

☐ **Personal Support Services**

Frequency of Support (i.e. Daily, BID):

Focus of Intervention
(i.e. AM care, sponge bathing, showering, incontinence care, transferring):

☐ **Nursing** (*include updated medical orders as applicable)

Frequency (i.e. Daily, BID):

Focus of Intervention:

☐ **Occupational Therapy**

Frequency:

Focus of Intervention:

☐ **Physiotherapy**

Frequency:

Focus of Intervention:

☐ **Other** (please describe):

Frequency (i.e. Daily, BID):

Focus of Intervention:

Referral Completed By:	Contact Phone Number:	Contact Fax Number #: