



Patient Transition to Ontario Health atHome Referral Form

Service Provider Organizations (SPOs) 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 SPO agency providing care:	
Primary Reason for Referral:	
Services Requested through OH atHome (include frequency):	
Start date with Ontario Health atHome:	
ODB required (Y/N):	
Supplies and equipment Requested from Ontario Health atHome:	

B. Patients 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:

Position:

Contact#: