HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

Telehomecare – COPD and Heart Failure Remote Monitoring Program

Please fax to: 613-745-8243 or 1-800-274-6955

Referral Form

*If referring for COVID-19 Remote Monitoring Program, please use Telehomecare COVID-19 Remote Monitoring Referral Form

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

Patient Information

Referral Date: Click or tap to enter a date.

Last Name	First Name	Date of Birth (DD MM YYYY) Click or tap to enter a date.
Health Card Number (OHIP)	VC	Gender
Address	City	
Postal Code	Primary Phone Number	Mobile Number
First Language	Second Language	

Eligibility for Telehomecare Services

☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).

☐ Health care provider feels patient will benefit from Telehomecare (this would require patient or caregiver being able to operate simple equipment)

☐ Frequent ED visits/ hospital admissions/ visits to primary care provider and/or difficulty managing symptoms of disease (i.e., anxiety, shortness of breath, edema).

☐ Patient or caregiver is able to provide informed consent to participate.

Main Diagnosis for Monitoring ☐ COPD ☐ Heart Failure

Co-morbidities

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other

Physiologic Parameters the following patient vitals will be monitored:

Heart Failure 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	Weight (lbs.)
High					
Low					

Referrer's Information I would like to receive patient reports ☐ Yes ☐ No

Name	Position	CPSO/CNO Number
Organization		Name / Address Stamp
Address		
Phone Number	Fax Number	

Primary Care Provider's Information ☐ Same as above

Is PCP interested in receiving patient reports? ☐ Yes ☐ No ☐ N/A

Name	Position	CPSO/CNO Number
Organization		Name/Address Stamp
Address		
Phone Number	Fax Number	

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

Medications

☐ Current medication list attached (or recorded below). ☐ Contact pharmacy for medication list

List medications and / or additional instructions and / or notes