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Ontario Health atHome

_____ _____
Last Name First Name

Date of Birth: _____
DD/MM/YYYY

Patient # _____

Affix Label or Print

HCN _____ Version Code_____

Referral for Ontario Health atHome Services

Relevant sections of this form must be completed in their entirety for processing to occur. Incomplete forms will be returned

☐ **Patient agreeable to referral to Ontario Health atHome**	
Address:	PO Box:
Town/City:	Postal Code:
Phone (Home): (Work):	(Cell):
Surgical Procedure: Date:_____	Planned Hospital Discharge Date:_____ DD/MM/YYYY
Allergies:	
Primary Diagnosis:	Secondary Diagnosis:

Palliative Approach to Care

☐ Diagnosis of a life-limiting progressive disease, not responsive to curative treatment ☐ Discussion has been had with patient and caregiver ☐ Goals of care include comfort, symptom management and quality of life ☐ Pain or symptom management concerns (*provide information below*) ☐ Would you be surprised if the patient died in the next 6 months: ☐ yes ☐ no 12 months: ☐ yes ☐ no	☐ DNR in home ☐ Expected death in the home PPS: ☐ 10-30% ☐ 40-60% ☐ 70-100%

Services Requested:	**Specific Orders/Request:**
☐ Nursing (MD/NP Orders Required)	MD/NP Orders:
☐ Personal Support	
☐ Physiotherapy	
☐ Occupational Therapy	
☐ Social Work	
☐ Speech-Language Pathology	
☐ Nutrition	
☐ Case Management	
☐ Rapid Response Nurse (COPD, CHF, Diabetes)	
☐ Nurse Practitioner	
☐ Medical Assistance in Dying Consultation	Additional relevant information:
Self-Management Programs	
☐ Telehomecare (COPD & Heart Failure)	
☐ Chronic Disease Self-Management Program	

Unless otherwise indicated, Ontario Health atHome may alter frequency of treatment as indicated by circumstance, arrange for teaching of the patient or other reliable person and/or request an assessment from other internal disciplines.

Referring Party Name/Designation (Print):

Referring Party Signature: **Date (DD/MM/YYYY):**

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE RECEIVED THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE. PLEASE CONTACT (807) 345-7339 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

Guidelines for Use Form HIS 759

1. This Ontario Health atHome Services form is a communication tool between the Ontario Health atHome and the patient's primary care provider.
2. The form is completed when the primary care provider wishes to:
    a. refer a patient for services in the community, and/or
    b. communicate the current medical condition of the patient.
3. Once completed, the form is transmitted to the Ontario Health atHome office to initiate an assessment by the Community Care Coordinator. The second copy may be retained by the hospital or primary care provider's office for their records.
    a. After regular business hours, or on the weekend, the form must be faxed to the Ontario Health atHome office (fax # 807-346-4625)
4. Upon receipt of a referral, the Community Care Coordinator must determine the patient's eligibility for services.
    a. If the client is eligible for Community Care services, the Coordinator may:
        i. Alter the frequency of treatment requested by the primary care provider, as indicated by circumstances,
        ii. Arrange for teaching of the patient or caregiver
        iii. Request an assessment from other internal disciplines.
    b. If the patient is not eligible, the referral will be processed as a non-admit and the client may be referred to other health care services.

Ontario Health atHome: Contact Numbers

Thunder Bay
Tel: 1-807-345-7339
Fax: 1-807-346-4625

Dryden
Tel: 1-807-223-5948
Fax: 1-807-223-3943

Sioux Lookout
Tel: 1-807-737-2349
Fax: 1-807-737-3017

Rainy River
Tel: 1-807-852-3955
Fax: 1-807-852-1077

Geraldton
Tel: 1-807-854-2292
Fax: 1-807-854-1805

Kenora
Tel: 1-807-467-4757
Fax: 1-807-468-1437

Red Lake
Tel: 1-807-727-3455
Fax: 1-807-727-2484

Marathon
Tel: 1-807-229-8627
Fax: 1-807-229-8628

Fort Frances
Tel: 1-807-274-8561
Fax: 1-807-274-0844

Atikokan
Tel: 1-807-597-2159
Fax: 1-807-597-6760

Nipigon
Tel: 1-807-887-5862
Fax: 1-807-887-1184

Ontario Health atHome
961 Alloy Dr. Thunder Bay, ON P7B 5Z8
Phone: 807-345-7339 | Toll-free: 1-800-626-5406
Fax: 807-346-4625

Fax To:
- ☐ Contracted Service Provider
- ☐ Dilico Ojibway C&FS
- ☐ Other

White Copy to Ontario Health atHome

Yellow Copy to TBRHSC/Physician's Office