Ontario Health atHome

RESET

141 Weber Street South
Waterloo ON N2J 2A9
Phone (Intake): 519 883 5500
Fax (Intake): 519 883 5550
Toll Free Phone: 1 888 883 3313
Hospital: Use hospital Ontario Health atHome Fax Number

Request for Services

If initiating referral for HPC services, please use Form 031B, "Request for Hospice Palliative Care Services"

Name _____

Address _____

City _____ PC _____

Phone _____ DOB _____

HCN _____ VC _____

OHIP: ☐ Yes ☐ No ☐ WSIB ☐ FIHP ☐ MVA

☐ Referral from Community: Phone Intake, complete this form in full, fax to Intake (phone & fax listed above)

☐ Referral from Hospital: Contact Ontario Health atHome, identify hospital/unit/floor ___, contact information _____
refer to back of this form for phone and fax numbers of Ontario Health atHome hospital offices

☐ Response Requested By: _____ Contact: _____

☐ The client or lawfully authorized substitute decision-maker has consented to this referral

☐ Please contact the person below (if not the client) for assessment purposes due to:

☐ Capacity ☐ Hearing/Language difficulties ☐ Interpreter Required If yes, what Language: _____

☐ Other _____

Contact Person _____ Relationship _____

Phone (H) Phone (C) Phone (W)

Requested Service(s)

Wherever feasible, treatment will be taught to the patient/ caregiver and services reduced when

☐ Dietetics
☐ Nursing
☐ RRN (complete WW586 *Hospital Only)
☐ Mental Health Nursing
☐ Occupational Therapy
  ☐ Wheelchair Assessment
  ☐ Home Safety Assessment
☐ Personal Support Services
☐ Physiotherapy
☐ Social Work
☐ Speech Language Pathology
☐ Care Coordination/System Navigation with Palliative Approach to

Reason for Referral:

☐ Wound Care Best Practice ☐ Total Contact Casting (TCC)

Wound Location _____

Note: Wound Care products may be substituted to a comparable product based on Ontario Health atHome supply list.

Primary Diagnosis _____ Date _____

Secondary Diagnosis _____

Primary Care Provider _____

☐ Current Medication List Attached ☐ Other Assessments Attached

Current Pharmacy _____

For parenteral and infusion therapy (i.e., medication, hydration), please complete form WW525

Medical Orders:

☐ Drain Care _____

☐ Urinary Catheter Care: ☐ Irrigate with ☐ cc NS until clear ☐ Removal Date _____

☐ Reinsert if unable to void ☐ Size Fr Catheter ☐ Change indwelling catheter ☐ Monthly ☐ Q 3 months ☐ Other

Name (please print) _____ ☐ MD ☐ RN(EC) Phone# (Private) _____

Signature _____ Date _____ Physician Billing/CNO# _____