HOME AND COMMUNITY CARE SUPPORT SERVICES
SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE

☐ Chatham Head Office
Ph: 310-CCAC (2222)
Fax: 519-351-5842

☐ Sarnia Branch
Ph: 310-CCAC (2222)
Fax: 519-337-4331

☐ Windsor Branch
Ph: 310-CCAC (2222)
Fax: 519-258-6288

COPD & Heart Failure Telehomecare Referral Form

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or provide any relevant information

Patient Information

Last Name	First Name	Date of Birth (dd/mm/yy)
Health Card Number	VC	Gender ☐ Male ☐ Female
Address	City	
Postal Code	Primary Phone 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 the patient will be capable of using simple in-home monitoring equipment.

☐ Patient lives in a residential setting with an active land line (internet or analog phone line).

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

Main Diagnosis for Monitoring

☐ COPD or ☐ Heart Failure

Co-Morbidities

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Cancer ☐ Other: _____

Referrer's Information

Name	Organization	Name/Address Stamp
Position	Other Description	
Address		
Phone Number	Fax Phone Number	

Primary Care Provider's Information ☐ Same as above

Name
Address

A complete and current medication list would be helpful. Please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges) if available.

Last Name	First Name	Date of Birth (dd/mm/yy)

Physiologic Parameters

The following patient vitals will be monitored:

CHF 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/ Day

The default parameters **ABOVE** will be used unless specific patient parameters are provided **BELOW**:

Patient	Systolic BP	Diastolic BP	Oxygen SAT.	Pulse
High				
Low				

Medications

☐ Current medication list attached (or can be recorded below)

☐ Contact pharmacy for medication list

List medications and/or additional instructions or notes

Referrer's Signature	Print Name / Designation / Title	Date (dd/mm/yy)
Primary Care Provider's Signature	Print Name / Designation / Title	Date (dd/mm/yy)

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately.

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