Telehomecare – Remote Monitoring Program
Referral Form

Please fax to:
613.745.8243 or
1.855.450.8569

1) Are you referring for nursing, PSS, OT, PT, dietician, SW or SLP services? If so, *do not use this form* and instead use our Medical Referral or Infusion Therapy / Venous Access Referral form.

2) Which program are you referring to?

a) Remote Monitoring for ☐ COPD ☐ Heart failure ☐ COVID-19 ☐ Diabetes

b) Enhanced In-Home Remote Monitoring Pilots, which include RRN visits, remote monitoring, community paramedics, hospital partnership. *** Hospital is responsible for faxing referral to Ottawa Community Paramedics or Prescott Russell Community Paramedics. ****

Which site? ☐ Hôpital Montfort ☐ Queensway Carleton Hospital

Which pilot? ☐ COPD ☐ Heart failure ☐ ALC ☐ Diabetes ☐ Cellulitis or osteomyelitis

3) Patient Information

Referral Date		Planned Discharge Date	
Last Name	First Name		DOB _____ (DD MM YYYY)
HCN (OHIP)		VC	Gender
Address		City	
Postal Code	Primary Phone	Mobile	
1st Language		2nd Language	

4) Eligibility (check all that apply)

☐ Patient has an established diagnosis (probable cases of COVID-19 are accepted)

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

☐ Health care provider feels patient will benefit from Telehomecare.

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

5) Main Diagnosis for Monitoring ☐ COPD ☐ Heart failure ☐ COVID-19 ☐ Diabetes

Co-morbidities:

☐ Diabetes ☐ COPD ☐ Heart failure ☐ Depression ☐ Hypertension
☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other

6) Physiologic Parameters - the following 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 you provide specific patient parameters BELOW:

Patient	Systolic BP	Diastolic BP	Oxygen Sat	Pulse	Weight (lbs.)
High					
Low					

7) Referrer Information

I would like to receive patient reports ☐ Yes ☐ No

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

8) PCP Information ☐ Same as above

Does PCP want to receive patient reports? ☐ Yes ☐ No ☐ N/A

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

9) Additional Information

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

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