

COVID-19 Remote Monitoring Program Referral Form

Patient Information

Please fax to: **1-855-352-2555**

LAST NAME	FIRST NAME	DATE OF BIRTH (DD MM YYYY)
HCN		GENDER
ADDRESS		CITY
POSTAL CODE	PRIMARY PHONE NUMBER	
FIRST LANGUAGE	SECOND LANGUAGE	POTENTIAL DISCHARGE DATE (DD MM YYYY)
EMAIL ADDRESS	CELL PHONE NUMBER	EMERGENCY CONTACT

Patients enrolled in the COVID-19 Remote Monitoring Program use an app on their smartphone to report their symptoms to their nurse. Please ensure that mobile phone number is clearly indicated:

MOBILE/CELL NUMBER: _____ Patient does not own a smart device

Eligibility for Referral (Patient must meet ALL the following criteria)

- | | |
|---|---|
| <input type="checkbox"/> COVID-19 Positive, OR | <input type="checkbox"/> Patient consents to participate in remote monitoring program |
| <input type="checkbox"/> HIGHLY PROBABLE, e.g.) direct contact with known COVID-19 case | <input type="checkbox"/> Patient is able to communicate with nurse in English |

Risk Factors

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes with complications | <input type="checkbox"/> Weakened immune system | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Extreme obesity |
| <input type="checkbox"/> Chronic lung disease (i.e. COPD, emphysema), or moderate to severe asthma | <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> >= 65 years old |
| | <input type="checkbox"/> Neurological conditions that weaken ability to cough | <input type="checkbox"/> On Home O ₂ , L/min: _____ |

Referrer Information

NAME AND CPSO #
POSITION
EXTENSION
LOCATION OF REFERRAL
OHIP BILLING #

Primary Care Provider's Information

NAME
PHONE NUMBER
FAX NUMBER

Additional Information (if relevant)