Ontario Health atHome

Referral/Request for Assessment

Patient Information

Surname			First Name
Home Address			
City			Postal Code
Health Card Number	Version Code	Date of Birth	Patient Telephone Number
Is patient aware of referral? ☐ Yes ☐ No	Alternate Contact		Alternate Contact Phone Number
Significant Medical Information/Symptoms			Communicable Diseases
Diagnosis			Surgical Procedure Date
Prognosis ☐ Improve ☐ Deteriorate ☐ Maintenance			Patient Aware of Prognosis ☐ Yes ☐ No
Allergies			

Form Instructions

Please return this form to Ontario Health atHome via fax.

London: 519-472-4045 (patients living in London/Middlesex and Elgin)

Stratford: 519-273-2847 or toll free: 1-855-223-2847 (patients living in Grey/Bruce, Huron, Oxford, Perth)

Equipment Orders

Height (cm/ In)	Weight (kg/lbs)	Estimated Discharge date
Equipment Requested (Formulary code, item description, details, e.g., handle height, delivery urgency)		

Surname	First Name	Health Card Number

Treatment Orders

☐ Ontario Health atHome Assessment	☐ CCP (Coordinated Care Plan)	Telehomecare ☐ COPD ☐ CHF

Other treatment orders:

Degree of Weight Bearing

☐ None ☐ Partial ☐ Full ☐ Progression

Wound Care Treatment Orders

Wound Diagnosis	Compression Therapy requires ABPI measurements
☐ Maintenance ☐ Healable ☐ Non-healable	VLU ABPI: Date:

Patients receiving wound care service within Ontario will be provided service according to the Ontario Health atHome Wound Care Management program, unless otherwise indicated.

1) Treatment is taught and services will be reduced, as appropriate.
2) Wound care orders outside of Best Practice guidelines may not be eligible for Ontario Health atHome services.
3) Wound care products may be substituted to a comparable product based on Ontario Health atHome formulary.

Referral Source Information

Referring Physician or Nurse Practitioner (print)	Signature
Telephone	Date
Family Physician Name	☐ Same as referral physician
Form Initiated By (if other than referring physician or nurse practitioner)	Position

Signature	Telephone Number	Date

A **referring physician or nurse practitioner signature and date is required at the time of referral**, if the treatment orders require such signature. Information entered by person other than the physician must be signed and dated.