Ontario Health atHome

Fax completed form to: 519-742-0635
Number of pages (including cover):

Add Patient Label Here

Cambridge Memorial Hospital | Groves Memorial Community Hospital | Guelph General Hospital | North Wellington Health Care | St. Joseph's Health Centre Guelph | WRHN Waterloo Regional Health Network

LETTER OF UNDERSTANDING

_____(insert patient's name), your current care needs no longer require an acute hospital setting. The health care team has that your needs may be med within the services offered in a rehabilitative care program. These programs are regional programs, offered at multiple sites within Waterloo Wellington:

- ☐ General Rehabilitation
- ☐ Stroke Rehabilitation
- ☐ Low Intensity Rehabilitation
- ☐ Complex Medical Management
- ☐ Chronic Ventilator / Respiratory Program

Site	General Rehab	Stroke Rehab	Low Intensity Rehab	Complex Medical Management	Chronic Ventilator / Respiratory Program
Waterloo Regional Health Network @ Chicopee in Kitchener	✓	✓	✓	✓	✓
St. Joseph's Health Centre in Guelph	✓	✓	✓	✓	

Referrals are coordinated by Ontario Health atHome Waterloo Wellington. Your health care team will be sharing your medical and personal information with Ontario Health atHome WW and the rehabilitative care program. Ontario Health atHome WW will add your name to the waiting list. Your initials and gender will be accessible to Ontario Health atHome WW's other hospital partners.

You will be notified by your health care team when a bed becomes available for you. The first available bed may be located at any one of the locations listed above. The health care team will assist you to arrange the transfer to the Rehabilitation program.

I have reviewed and understand the above information. I agree to proceed with the rehabilitative care program referral process. I understand that my personal and health information will be shared with Ontario Health atHome WW and the rehabilitative care sites within the region.

Patient Name:

Patient/Substitute Decision Maker's (SDM) Signature:

Print SDM Name: Date:

Verbal/telephone agreement Documentation (if signature not possible)

Consent Obtained From: Date:

Signature of Staff Member:

Printed Name of Staff Member obtaining consent: