Ontario Health atHome

Request for Ontario Health atHome Services

Patient Name _____ HCN _____ VC _____ DOB _____

Address _____ City _____ Province _____ Postal Code _____

Patient Phone _____ Contact Name _____ Contact Phone _____

☐ Community: Fax completed form to 1-866-655-6402 ☐ Hospital: Fax completed form to OHaH hospital office (see pg. 2);

Hospital Referrals: Unit/floor _____ Planned Hospital Discharge Date _____

☐ Bundle Holder Referral for Service – Hospital Site _____ Bundle Type _____

☐ The patient or lawfully authorized substitute decision maker has consented to this referral

☐ Please contact the person below (rather than the patient) for assessment, due to:

☐ Patient Preference ☐ Hearing Difficulties ☐ Cognitive Status ☐ Language Difficulties ☐ Other _____

Contact Person _____ Relationship _____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____

Primary Care Physician _____ Phone _____

Primary Diagnosis _____ Date _____

Secondary Diagnosis _____ Diagnosis Discussed With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No

Prognosis ☐ Improved ☐ Remain Stable ☐ Deterioration Prognosis Discussed With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No

Surgical Procedure _____ Date _____

Current Medications ☐ Medication List Attached ☐ Health Profile Attached WSIB Claim ☐ Yes ☐ No

Allergies _____ Special Diet _____

Wound **Care** (Include location)_____

Note: If not specified, nurse will assess and provide recommendations. Wound care products may be substituted to a comparible product based on supply list.

Weight Bearing ☐ Full ☐ Partial ☐ Feather ☐ None Activities Permitted _____

Completion of additional forms are required for the following protocols *(select link to open form)*:

Central Vascular Devices Vancomycin & Aminoglycoside Prescriptions Protocol for First Dose IV

☐ Activities of Daily Living	☐ Behavioural Supports (e.g. BSO)	☐ Chronic Disease Management
☐ Community Support Services/ Resources	☐ Dementia/ Memory Impairment	☐ Health Link Patient
☐ Home Safety	☐ Housing Options	☐ Medication Management
☐ Mobility/ Risk of Falls	☐ Pain Management	☐ Palliative Care/ End of Life - PPS% _____
☐ Social Isolation	☐ Strengthening	☐ Speech Language Pathology

Medical Orders: ☐ Same Day Request ☐ *Additional information attached. Total Number of Pages* _____

☐ Indwelling Urinary Catheter Care: Insertion Date: _____ Size: _____ Type: _____

Standard maintenance for Indwelling or Suprapubic Catheter: Change latex catheter monthly and PRN, Change silastic and silicone – silicone coated catheters every 3 months and PRN. Irrigate catheter with 50-100 mL Normal Saline PRN.

Note: if size/type not specified, standard foley catheter kit will be provided with #14 & 16 silicone coated catheter for nurse to use discretion

Thank you for your referral. Ontario Health atHome will assess and work with your patient to develop a care plan that includes service location, frequency and health teaching to support independence. For questions please call 1 800 810 000 from 8:30 am to 8:30 pm, 7 days a week.

Name _____ ☐ MD ☐ NP Telephone _____

(Please Print)

Signature _____ Date _____ CPSO/CNO Reg. # _____

Print Clear

Version **23-001**

Ontario Health atHome

Hamilton Niagara Haldimand Brant

Fax Numbers Overview

All Community Referrals, Including Primary Care Providers Please fax all community referrals to Intake and Extended Hours teams	Fax Number for All **1-866-655-6402**

For hospital-based referrals, please fax directly to the appropriate Ontario Health atHome hospital office:

Brantford/Burlington/Haldimand-Norfolk Hospitals	
Brant Community Healthcare System Joseph Brant Hospital Haldimand War Memorial Hospital Norfolk General Hospital West Haldimand General Hospital	Fax Number for All: **1-866-568-4418**

Hamilton Hospitals	
Hamilton General Hospital Juravinski Hospital Juravinski Cancer Centre McMaster University Medical Centre St. Joseph's Healthcare Hamilton *(Charlton and West 5th Campuses)* St Peters Hospital Satellite Health Facility West Lincoln Memorial Hospital	Fax Number for All: **1-866-271-7907**

Niagara Hospitals	
Fort Erie Site Hotel Dieu Shaver Marotta Family Hospital *(St. Catharines Site)* Niagara Falls Site Port Colborne Site Welland Site	Fax Number for All: **1-866-391-9467**