Ontario Health atHome

Please fax to:
613.745.8243 or
1.855.450.8569

Telehomecare – Remote Monitoring Program

Referral Form

1) **Non-Enhanced Program:** ☐ COPD ☐ COVID-19 ☐ Diabetes ☐ Heart failure ☐ Frail Elderly ☐ Geriatric rehab

2) **Enhanced In-Home Program** * only for participating hospital sites. ☐ Cellulitis ☐ COPD ☐ Diabetes ☐ Frail Elderly ☐ Geriatric rehab ☐ Heart failure ☐ Osteomyelitis. * **Hospital employees** are responsible for faxing referral to Community Paramedics.

Designated Alternate Level of Care (ALC)?	☐ Yes	☐ No
Early Discharge Program?	☐ Yes	☐ No

3) **Patient Information**

Environmental/Safety Alert: ☐ Pets ☐ Hoarding ☐ Smoking/ Vaping ☐ Infestation ☐ Other		Additional information:	
Referral Date		Planned Discharge Date	
Last Name	First Name	DOB	_____ (DD MM YYYY)
HCN (OHIP)		VC	Gender
Address		City	
Postal Code	Primary phone		Other phone
Language(s) 1st		2nd	

4) **Alternate Contact** ☐ Instead of the patient, contact the alternate for assessment due to: ☐ Hearing ☐ Cognition ☐Preference ☐ Language ☐ Other (specify) _____

Alt Name	Phone
Relationship to patient	

5) Patient Health Information

Height	Weight
Primary Diagnosis	

6) Other Services

Are you referring for **nursing, PSS, OT, PT, dietician, SW or SLP** services **in addition to the Remote Monitoring Program?**

If yes, please **also** complete and submit the Medical Referral Form or the Parenteral Therapy Referral (Orders), as appropriate.

7) Default Parameters - the following will be monitored, unless you provide other specifics, below.

Heart Failure					
Parameter	Significant Lower Limit	Marginal Lower Limit	Marginal Upper Limit	Significant Upper Limit	Change Alerts
Pulse(bpm)	49	59		101	
Weight (lbs)					2.00 lbs over 1 day 5.00 lbs over 7 days
SBP (mmHg)	85	89	150	180	
DBP (mmHg)	39	60	100	105	
SpO2 (%)	88	90		101	

COPD					
Parameter	Significant Lower Limit	Marginal Lower Limit	Marginal Upper Limit	Significant Upper Limit	Change Alerts
Pulse(bpm)	49	59		101	
Weight (lbs)					2.00 lbs over 1 day 5.00 lbs over 7 days
SBP (mmHg)	85	90	150	180	
DBP (mmHg)	39	60	100	105	
SpO2 (%)	88	90		101	

Patient-Specific Parameters (if not using parameters above)

Patient					
Parameter	Significant Lower Limit	Marginal Lower Limit	Marginal Upper Limit	Significant Upper Limit	Change Alerts
Pulse(bpm)					
Weight (lbs)					
SBP (mmHg)					
DBP (mmHg)					
SpO2 (%)					

8) Referrer Information I would like to receive patient reports ☐ Yes ☐ No

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

9) PCP Information ☐ Same as above**.** Does PCP, specialist or outpatient clinic want to receive patient reports? ☐ Yes ☐ No ☐ N/A

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

10) Additional Information

a) What information have you shared with the patient about symptom management, titrating their medications, and / or taking PRN medications?

b) If available, **please also attach** other information (consultant notes, lab or imaging reports, patient-specific health care challenges).

11) **Medications** please list them here, or attach (mandatory)

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