

COPD & Heart Failure Telehomecare Referral Form

Please fax referral form(s) to: 807-767-6968

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or add any relevant information.

PATIENT INFORMATION

| | | | |
|---------------------------|----------------------|--|--|
| LAST NAME | FIRST NAME | DATE OF BIRTH (DD-MM-YYYY) | |
| HEALTH CARD NUMBER (OHIP) | VC | GENDER MALE FEMALE | |
| ADDRESS | | CITY | |
| POSTAL CODE | PRIMARY PHONE NUMBER | | |
| FIRST LANGUAGE | SECOND LANGUAGE | | |

ELIGIBILITY FOR TELEHOMECARE SERVICES

- | | |
|--|---|
| <input type="checkbox"/> Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions). | <input type="checkbox"/> Health care provider feels the patient will be capable of using simple in-home monitoring equipment. |
| <input type="checkbox"/> Patient lives in a residential setting with an active land line (internet or analog phone line). | <input type="checkbox"/> Patient or family caregiver is able to provide informed consent to participate. |

MAIN DIAGNOSIS FOR MONITORING

COPD or Heart Failure

CO-MORBIDITIES

Diabetes COPD Heart Failure Depression Hypertension
 Anxiety Arthritis Osteoporosis Cancer Other _____

REFERRER'S INFORMATION

| | | |
|--------------|-------------------|--------------------|
| NAME | ORGANIZATION | NAME/ADDRESS STAMP |
| POSITION | OTHER DESCRIPTION | |
| ADDRESS | | |
| PHONE NUMBER | FAX PHONE NUMBER | |

PRIMARY CARE PROVIDER'S INFORMATION

Same as above

| |
|---------|
| NAME |
| ADDRESS |

A complete and current medication list would be helpful. Please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges) if available.

REFERRER'S SIGNATURE _____

DATE (DD-MM-YYYY) _____

PRIMARY CARE PROVIDER'S SIGNATURE _____

DATE (DD-MM-YYYY) _____

NOTE: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately.

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PHYSIOLOGIC PARAMETERS

The following patient vitals will be monitored:

| CHF DEFAULT | SYSTOLIC BP | DIASTOLIC BP | OXYGEN SAT. | PULSE | WEIGHT (lbs.) |
|----------------|----------------|-----------------|----------------|-------|------------------|
| High | 150 | 100 | 100 | 100 | +2 lbs/ DAY |
| Low | 90 | 60 | 92 | 50 | -5 lbs/ DAY |

| COPD DEFAULT | SYSTOLIC BP | DIASTOLIC BP | OXYGEN SAT. | PULSE | WEIGHT (lbs.) |
|-----------------|----------------|-----------------|----------------|-------|------------------|
| High | 150 | 100 | 100 | 100 | +5 lbs/ WEEK |
| Low | 90 | 60 | 88 | 50 | -5 lbs/ WEEK |

The default parameters **ABOVE** will be used unless specific patient parameters are provided **BELOW**:

| PATIENT | SYSTOLIC BP | DIASTOLIC BP | OXYGEN SAT. | PULSE |
|---------|----------------|-----------------|----------------|-------|
| High | | | | |
| Low | | | | |

MEDICATIONS

- Current medication list attached (or can be recorded below)
- Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES