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Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

# COPD & Heart Failure Telehomecare Referral Form

Please fax referral forms(s) to: 705-670-3805

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

## PATIENT INFORMATION

**Referral Date** (DD MM YYYY): ____/____/____

| 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

- ☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).
- ☐ Patient lives in a residential setting with an active land line (internet or analog phone line).
- ☐ Health care provider feels the patient will benefit from Telehomecare. (This would require the patient or caregiver being able to operate simple equipment.)
- ☐ Patient or family caregiver is able to provide informed consent to participate.

## MAIN DIAGNOSIS FOR MONITORING

○ COPD ○ Heart Failure

## CO-MORBIDITIES

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other _____

## REFERRER'S INFORMATION

☐ I would like to receive patient reports

| NAME | ORGANIZATION | CPSO/CNO NUMBER |
|---|---|---|
| | | |

| POSITION | OTHER DESCRIPTION | NAME/ADDRESS STAMP |
|---|---|---|
| | | |

| ADDRESS | |
|---|---|
| | |

| PHONE NUMBER | FAX PHONE NUMBER |
|---|---|
| | |

## PRIMARY CARE PROVIDER'S INFORMATION

☐ Same as above

| NAME | CPSO/CNO NUMBER |
|---|---|
| | |

| 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.**





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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